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United States
Department of Defense



Special Plans and Operations

Assessment of DoD Wounded Warrior Matters - Camp Lejeune

Report Documentation Page

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INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
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March 30, 2012

MEMORANDUM FOR DISTRIBUTION

SUBJECT: Assessment of DoD Wounded Warrior Matters – Camp Lejeune
(Report No. DODIG-2012-067)

This report discusses the U.S. Marine Corp's Warrior Care and Transition Programs at Camp Lejeune, North Carolina, and is the third in a series of site reports that will discuss the care, management, and transition of recovering Service members.

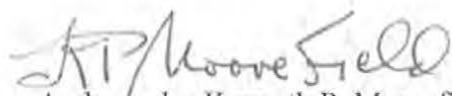
We are providing this report for review and comment. We considered management comments on a draft of this report when preparing the final report. Some of these comments were partially responsive, and we have revised one recommendation.

We request additional comments on recommendations by April 30, 2012 as follows:

- Secretary of the Navy: We request additional comments on Recommendation D.2.
- Undersecretary of Defense for Personnel and Readiness: We request additional comments on Recommendation D.3.
- Office of the Secretary of Defense, Health Affairs: We request notification be provided as progress is made towards updates in Recommendation D.4.1.
- Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery: We request additional comments on Recommendations D.1.1. a., D.4.2. (a)-(b), and D.4.3.

DOD Directive 7650.3 requires that recommendations be resolved promptly. If possible, send a .pdf file containing your comments in electronic format (Adobe Acrobat file only) to spo@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We are unable to accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to our staff during the conduct of this project. Please direct questions to Dr. Elias G. Nimmer [REDACTED]


Ambassador Kenneth P. Moorefield
Deputy Inspector General
Department of Defense

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Results in Brief: Assessment of DoD Wounded Warrior Matters – Camp Lejeune

What We Did

We assessed whether the programs for the care, management, and transition of Wounded Warriors (who include Wounded, Ill, or Injured Marines, hereafter, “Warriors”) located at the Camp Lejeune, Wounded Warrior Battalion - East (hereafter, “WWBn-East”) were managed effectively and efficiently. Specifically, we evaluated the missions, policies, and processes in place to assist Warriors in their return to duty status or transition to civilian life, and the DoD programs for Warriors affected with Traumatic Brain Injury and Post Traumatic Stress Disorder.

What We Found

We identified several initiatives implemented at both WWBn-East and the Naval Hospital Camp Lejeune that we believed to be noteworthy practices for supporting the comprehensive care, healing, and transition of Warriors. Further, we observed that the WWBn-East and Naval Hospital Camp Lejeune management and staff were fully dedicated to providing the best available care and services for helping Warriors heal and transition.

We also identified a number of significant challenges that we recommend the WWBn-East and Naval Hospital Camp Lejeune management address, which if resolved, we believe will increase program effectiveness in providing quality and timely care and services in support of the Warriors healing and transition.

Finally, we recognized as a result of this assessment, that it was important to give a voice to the Warriors themselves. We suggest that the WWBn-East and Naval Hospital Camp Lejeune management and staff consider Warrior comments, as discussed in this report, so they are cognizant of the Warriors’ views and concerns and can take appropriate action.

What We Recommend

We recommend that the WWBn-East and the Naval Hospital Camp Lejeune management:

- Develop procedures to ensure Warriors are active participants in the development of their Comprehensive Training Plans
- Develop comprehensive training program for recovery team members to help Warriors heal, recover and transition
- Update and implement policies and procedures for medication management, polypharmacy and medication reconciliation
- Establish procedures for the disposal of prescription medications no longer needed by the Wounded Warrior
- Ensure timely access to specialty medical care
- Ensure there are dedicated primary care managers throughout all Marine Wounded Warrior sites to ensure primary care oversight and continuity

Management Comments and Our Response

Those offices listed on the recommendations table on the back of this page either concurred or non-concurred with comments to our recommendations. However, there are several recommendations that require additional comments. Therefore, we request that the Secretary of the Navy, Undersecretary of Defense for Personnel and Readiness, and the Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery provide additional comments to the final report by April 30, 2012.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
Undersecretary of Defense for Personnel and Readiness	D.3.	
Office of the Secretary of Defense, Health Affairs	D.4.1.	
Secretary of the Navy	D.2.	
Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery	D.1.1.a., D.1.1.b., D.4.2.a., D.4.2.b., D.4.3.	D.1.1.c.,
Commanding Officer, Navy Medicine East		D.4.3.
Commanding Officer, Wounded Warrior Regiment		D.2.1.a., D.2.1.b., D.2.1.c., D.2.1.d., D.2.1.e.
Commanding Officer, Wounded Warrior Battalion – East		C.1., C.2., C.3.1. a., C.3.1.b., C.3.1.c.,
Commanding Officer, Naval Hospital Camp Lejeune		D.1.2., D.4.4.a., D.4.4.b.

Please provide comments by April 30, 2012.

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Introduction

Objectives

The broad objective of this ongoing assessment is to determine whether the DoD programs for the care, management, and transition of recovering Service members wounded during deployment in Operation Iraqi Freedom or Operation Enduring Freedom were managed effectively and efficiently.¹

Specific Objectives

Our specific objectives were to evaluate the missions, the policies, and processes of:

- Military units, beginning with the Army and Marine Corps, established to support the recovery of Service members and their transition to duty status (Active or Reserve Components)² or to civilian life; and
- DOD programs for Service members affected with Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD).

Assessment Approach

We conducted this assessment in response to a request to the DoD IG made by Congressman Walter B. Jones (R-NC) in February 2009. Congressman Jones received complaints from constituents about incidents that allegedly occurred at the Wounded Warrior Battalion-East (WWBn-East) at Camp Lejeune, North Carolina. As a result of a meeting with Congressman Jones and his staff, we agreed to assess Wounded Warrior matters in a systemic approach across DoD, beginning with the Army and the Marine Corps.

We interviewed several of Congressman Jones' constituents both prior to and during our site visit to Camp Lejeune to obtain information about the program and the alleged concerns; however, because those constituents were no longer part of the WWBn-East at the time of our site visit, the information they provided was not directly used in support of the observations and conclusions in this report. Rather, this information was used to help frame the interview questions we used during our visit to Camp Lejeune in the fall of 2010.

This is the third of multiple assessments that will be conducted at Army and Marine Corps Warrior transition units. To obtain unbiased data, not unduly reflecting the views of either the supporters or detractors of the program, we used a two-pronged approach to select our respondents. First, we determined how many Service members were required to be interviewed, then we applied a simple random sample approach to determine the Service members we should

¹ The Marines referred to in this assessment were wounded, ill and injured personnel who were under the responsibility of the Wounded Warrior Battalion-East in Camp Lejeune, North Carolina. The Wounded Warrior Regiment estimates that approximately 60 percent of Marines in the Wounded Warrior Battalions were combat wounded.

² The Marine Corps is a branch of the United States Armed Forces and is comprised of Active Duty Marines and Reserve Marines; the Army is comprised of two distinct and equally important components, the Regular Army (the Active Component), and the Army National Guard and the Reserve (the Reserve Components).

interview, as described in Appendix A. We subsequently performed interviews with Marine Corps wounded, ill, and injured personnel (hereafter referred to as Warriors), to include 64 individual interviews with Marines, and 24 additional Marines in 4 group interviews.

Second, we interviewed all available members of the key groups responsible for the Warriors' care. Specifically, we conducted meetings and interviews during our 2-week visit at Camp Lejeune that included unit commanders, staff officers, and WWBn-East military staff, as well as civilian staff and contractors. A list of the meetings and interviews conducted at the Naval Hospital Camp Lejeune and WWBn-East is in Appendix A, along with the scope, methodology, and acronyms of this assessment. The prior coverage of this subject area is discussed in Appendix B.

The observations and corresponding recommendations in this report focus on what we learned at Camp Lejeune, but we believe that some of our findings may have implications for other Wounded Warrior units and should be called to the attention of higher headquarters responsible for these programs.

Additional reports and/or assessments may be subsequently performed by the DoD Office of the Inspector General on DoD Wounded Warrior matters or other related issues as they are identified. A current list of specific issues, concerns, and challenges that we identified at the WWBn-East that may be addressed in future assessments and/or reports to organizations other than those located at the Army and Marine Corps installations we visited are discussed in Appendix C.

Background

U.S. Marine Corps Wounded Warrior Regiment

The 34th Commandant of the Marine Corps, Gen. James T. Conway, in his 2006 Planning Guidance, highlighted his vision of taking care of Wounded Warriors and their families. Consequently, the U.S. Marine Corps Wounded Warrior Regiment (WWR), was established in 2007 to provide and facilitate non-medical care to combat and non-combat wounded, ill and injured Marines, and Sailors attached to or in direct support of Marine units and their family members in order to assist them to return to active duty or transition successfully to civilian life.

The Regimental Headquarters element, located in Quantico, Virginia, maintains administrative and operational control of two Wounded Warrior Battalions located at Camp Lejeune, North Carolina (WWBn-East) and Camp Pendleton, California (WWBn-West). The Regimental Headquarters provides unity of command and unity of effort through a single Commander who provides guidance, direction, and oversight to the Marine Corps Warriors non-medical care process and ensures continuous improvements to care management and the seamless transition of recovering Marines. The Regiment's nerve center is the Wounded Warrior Operations Center, which serves as the central point of contact for all non-medical care management issues.

The mission of the WWR, according to their Promulgation Statement, is the following:

The Wounded Warrior Regiment will provide and facilitate assistance to ill/injured Marines, Sailors attached to or in support of Marine units, and their family members, throughout the phases of recovery.

The WWR's motto is "Still in the fight" which helps to focus a recovering Marine on "ability" versus "disability." The WWR strives to focus the mindset of these Warriors on their ability to overcome their disabilities and personal challenges to thrive in all areas of their lives. Focusing on ability provides the psychological and emotional support to encourage healing and a quicker adaptation to injury and leads to an increased ability for these Warriors to thrive within their new normal.³

Since the WWR stood up in April 2007 it has provided support to nearly 27,377 wounded, ill, and injured Marines. Support may include Call Center contact, administrative support (benefits and compensation), psychological health referral, and family support, among others. Approximately 60 percent of these Marines were wounded in combat, and 40 percent had suffered injuries not associated with combat.

As written in the Wounded Warrior Regiment Handbook, December 2010, "Once a Marine, always a Marine" is an enduring commitment the WWR upholds. Whether Marines are wounded in combat, fall ill, or are injured in the line of duty, the WWR stands steadfast to serve the total Wounded, Ill and Injured (WII) force: active duty, reserve, retired, and veteran Marines."

Wounded Warrior Battalions

The WWBn-East is located in Camp Lejeune, North Carolina, while the WWBn-West is in Camp Pendleton, California. These battalions have Detachments located at Military Treatment Facilities (MTF) and at Department of Veterans Affairs (VA) Polytrauma⁴ Rehabilitation Centers. Table 1. shows the locations of Wounded Warrior Battalions.⁵

³ Reference to Focus on Ability taken from Wounded Warrior Regiment Handbook, December 2010, page 38.

⁴ "Polytrauma" was termed by VA to describe injuries to multiple body parts and organs occurring as a result of blast-related wounds seen in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Traumatic brain injury (TBI) frequently occurs in polytrauma in combination with other disabling conditions, such as amputation, auditory and visual impairments, spinal cord injury (SCI), post-traumatic stress disorder (PTSD), and other medical conditions. Due to the severity and complexity of their injuries, Veterans and Servicemembers with polytrauma can require an extraordinary level of coordinated and integrated clinical and other support services.

⁵ Wounded Warrior Battalion Locations are broken out by East and West sites as shown on the Wounded Warrior Battalion Detachments Fact Sheet at www.woundedwarriorregiment.org.

Table 1. Wounded Warrior Battalion Locations

Wounded Warrior Battalion – East Sites	Wounded Warrior Battalion – West Sites
Landstuhl Regional Medical Center, GE	Naval Hospital 29 Palms, CA
Walter Reed National Military Medical Center, Bethesda, MD ⁶	VA Polytrauma Center, Palo Alto, CA
Naval Hospital Portsmouth, VA	Naval Hospital Camp Pendleton, CA
Naval Hospital Camp Lejeune, NC	Balboa Naval Hospital San Diego, CA
San Antonio Military Medical Center, San Antonio, TX	Tripler Army Medical Center, Honolulu, HI
VA Polytrauma Center, Minneapolis, MN	Naval Hospital Okinawa, Japan
VA Polytrauma Center, Tampa Bay, FL	
Andrews Air Force Base, MD	

Active and Reserve Marines at the detachment sites are the primary interface with Warriors and their families. Specifically, through ongoing and personal interactions, they assist families with non-medical issues (e.g. pay, entitlements, travel and transportation, temporary lodging, etc.) allowing families to focus on their Warriors’ recovery. Additionally, they coordinate care and resources provided by governmental agencies and non-governmental benevolent organizations including the scheduling of special event and educational opportunities.

Each detachment commander reports directly to their respective battalion commander (e.g. WWBn – East or West.) The battalion commander reports to the Wounded Warrior Regiment commander. The U.S. Marine Corps relies on the other military services, the VA, or the civilian healthcare network to provide for the medical needs of Warriors. Specifically, the health care provided to each Warrior is coordinated by the closest MTF or VA. These MTF or VA care teams consist of, but are not limited to, military personnel, physicians, nurses, medics/corpsmen, medical case managers, and specialty providers such as TBI and behavioral health specialists (e.g. psychiatrists, psychologists, social workers, and family counselors) and a myriad of outside organizations offering resources to the Warriors.

The WWBn detachments and MTFs provide this critical support to Warriors who are referred and meet the eligibility criteria for entrance in the WWBn, which generally require that a wounded, ill, or injured Marine has a medical condition that will require 90 or more days of medical treatment and/or rehabilitation. Other considerations a commander can use to determine whether a Marine should be referred to a WWBn include the following: 1) Three or more medical appointments required per week; 2) Command cannot support transportation to and from

⁶ The 2005 Defense Base Realignment and Closure (BRAC) Commission recommended that DOD establish a new Walter Reed National Military Medical Center (WRNMMC) on the site of the current National Naval Medical Center (NNMC) in Bethesda, Maryland. The last patients at Walter Reed Army Medical Center were transported August 27, 2011 to the new location at WRNMMC.

appointments; and 3) the Marine cannot serve a function in their parent command due to his or her injuries or illness.

Personnel Support of the Wounded Warrior Battalions

There are several members of the team that support individual Warrior recovery and transition including, among others, the Warrior's Section Leader (also referred to as Platoon Leader), Medical Case Manager, Primary Care Manager and Recovery Care Coordinator.

Specifically, the following is a brief description of each member's roles and responsibilities.

- **Section (Platoon) Leader** – is a military Service member (senior non-commissioned officer)⁷ who plays a key leadership role in supporting the Marine through the recovery process and helps them complete actions necessary to meet their transition goals as outlined in their Comprehensive Transition Plan (CTP)⁸. The Section Leader combines the discipline and standards of the Marine Corps with an understanding of the obstacles Warrior Marines face while serving as their advocate to ensure coordinated medical and non-medical recovery efforts. WWR guidelines indicate that Section Leaders support their wounded, ill and injured Marines on a 1:10 ratio.
- **Medical Case Manager** – is usually a civilian employee who “assesses, plans, implements, coordinates, monitors and evaluates options and services” to meet the Warriors' complex health needs. The medical case manager helps to coordinate medical appointment schedules and other medical related activities.
- **Primary Care Manager** – is either a military or civilian health care provider (e.g. physician, physician's assistant, or nurse practitioner) who is the medical point of contact and healthcare advocate for the Warrior. They provide primary oversight and continuity of healthcare and are to ensure the level of care provided is of the highest quality. They are the gateway to all specialty care (such as behavioral health specialists or orthopedic surgeons) and they coordinate with other physicians to ensure that the Warriors are getting the treatment that they need.
- **Recovery Care Coordinator (RCC)** – is usually a civilian employee who serves as the Warrior's primary point of contact to help them define their individual goals for recovery, rehabilitation, and community reintegration. Additionally, the RCC identifies the services and resources needed to achieve these goals and develops the CTP that guides the Warrior during their transition.

⁷ A senior non-commissioned officer is an enlisted member of the armed forces, appointed to a rank conferring leadership over other enlisted personnel.

⁸ The primary tool used to coordinate a recovering Marine's and their family's care is the Comprehensive Transition Plan (CTP). This plan is based on information from the Marine's recovering needs assessment, which takes into consideration various components such as employment, housing, financing, counseling, family support, disability evaluation process, among others. The CTP is referred to as a “life map” for the recovering Marine and their family and reflects their medical and non-medical goals and milestones from recovery and rehabilitation to community reintegration.

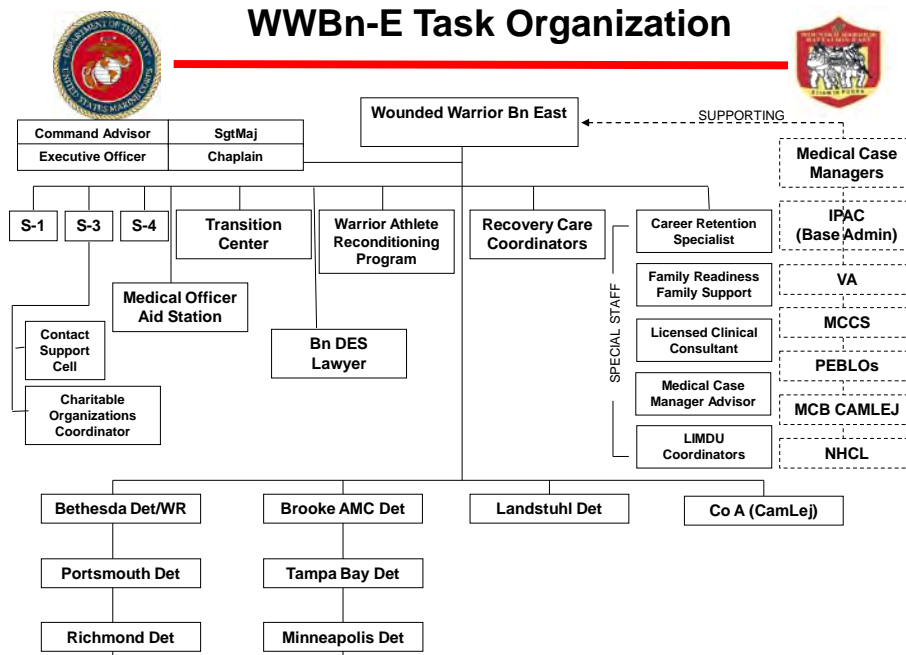
Camp Lejeune, North Carolina

Camp Lejeune is located on the Eastern Coast near Jacksonville, NC. The base and surrounding community is home to an active duty, dependent, retiree and civilian employee population of approximately 180,000. The nearest large city (Raleigh, NC) is approximately 100 miles away and has a population of approximately 276,093.

Camp Lejeune's mission is to maintain combat-ready units for expeditionary deployment. Camp Lejeune is the home base for the II Marine Expeditionary Force, 2nd Marine Division, 2nd Marine Logistics Group and other combat units and support commands. There are several major Marine Corps commands and one Navy command aboard Camp Lejeune and several tenant commands which include the Naval Hospital and the Wounded Warrior Battalion-East. The Naval Hospital provides primary medical care to service members and their families stationed at Camp Lejeune and Marine Corps Air Station New River. The Naval Hospital Commander does not exercise command and control over the Wounded Warrior Battalion-East. Rather, the Naval Hospital Commander provides direct medical support to the Wounded Warrior Battalion-East as he does to all other units at Camp Lejeune and Marine Corps Air Station New River.

The Wounded Warrior Battalion-East organizational structure that supported the Warriors in the battalion is shown in Figure 1.

Figure 1. Wounded Warrior Battalion – East



Camp Lejeune Wounded Warrior Battalion- East (WWBn-East)

As of September 30, 2010, the WWBn-East had approximately 121 Marines, Sailors and civilian professionals dedicated to ensuring the health, welfare, and morale of approximately 194 Warriors. WWBn-East consisted of a headquarters element in support of all detachments and two companies (Alpha and Bravo) that supported wounded, ill and injured Marines physically present at Camp Lejeune. The mission statement of the WWBn-East was to:

“Provide continuous, far-reaching leadership to wounded, ill, or seriously injured Marines and designated Sailors worldwide in order to ensure all wounded warriors and families successfully transition back to full duty or civilian life.”

The WWBn-East included seven detachments geographically dispersed over six U.S. States (Maryland, North Carolina, Virginia, Texas, Florida, and Minnesota) and one detachment located at Landstuhl, Germany. Our assessment focused on those personnel geographically located at WWBn-East headquarters Camp Lejeune, North Carolina. Additionally, the WWBn-East headquarters included a number of special staff elements in support of a Warrior’s transition including, but not limited to, a Career Retention Specialist, Family Readiness Support Coordinator, Medical Case Manager Advisor, Licensed Clinical Consultant and Limited Duty Coordinators. In addition, there were Recovery Care Coordinators, a Disability Evaluation System Lawyer, and a Warrior Athlete Reconditioning program coordinator.

The majority of the Warrior’s medical care was provided by the U.S. Navy hospital located on the base, with the remainder of the services being coordinated by the TRICARE healthcare contractor utilizing off-base civilian health care providers and facilities.

Of the 194 Warriors assigned to the WWBn-East as of September 30, 2010, 130 were combat wounded in the theater of operations.

Between April 2007 and the completion of our site visit on September 30, 2010, the WWBn-East transitioned a total of 696 Marines. Table 2 shows the status of the Warriors.

Table 2. Status of Warriors Who Transitioned Through the WWBn-East

Return to Active Duty	36
Transitioned from the U.S. Marine Corps to Civilian Life	324
Deceased	6
Administrative or Adverse Actions	3
Remaining in Transition	317
Marine Reservists (8 returned to reserve unit, and 2 transitioned to civilian life)	10
Total Warriors in Transition	696

Naval Hospital Camp Lejeune

The Naval Hospital at Camp Lejeune and its 5 branch clinics⁹ have a staff of nearly 2,000 active duty, civil service and contract personnel supporting a beneficiary population of over 118,000, including: active duty, family members of active duty, retired service members and their families. The Naval Hospital Camp Lejeune provides both inpatient¹⁰ and ambulatory care¹¹ services, which includes, but was not limited to:

- Primary Care¹² – family medicine, internal medicine, pediatrics, and branch clinics
- Specialty Care – mental health, emergency medicine, internal medicine, anesthesia/pain management, surgery (general; ear, nose, and throat (ENT); eye; urology), OB/GYN, orthopedics (general, hand specialist, podiatry, spine surgery), physical therapy, occupational therapy, sports medicine, chiropractic, dental (general/pediatric), dermatology, occupational health, optometry, speech therapy, and neuropsychology
- Clinical Support Services – preventive medicine, health promotion, nutrition management, substance abuse program, deployment health center, laboratory, pharmacy, radiology

Traumatic Brain Injury and Post Traumatic Stress Disorder

Two most increasingly common diagnoses for recovering Service members are TBI¹³ and PTSD.¹⁴ TBI is also referred to by its common term, “concussion,” which occurs when someone receives a direct blow or a jolt to their head that may disrupt the function of the brain. Service members may sustain concussions or TBIs when exposed to a blast or explosion (sometimes on multiple occasions), which may lead to serious symptoms that may not be immediately apparent. There are three different levels of TBI (mild, moderate, and severe) based on the severity of damage to the brain.

PTSD is an anxiety disorder or condition that develops after someone has experienced or witnessed a life-threatening or traumatic event, which may include a combat event. PTSD symptoms often begin immediately after the traumatic event but may not be evident until years later. A PTSD event likely involves actual or perceived death or serious injury and causes an intense emotional reaction of fear, hopelessness, or horror.

⁹ Branch Clinic is defined as having at least one of the following capabilities: medical, dental and/or occupational medicine; and is subordinate to a larger facility.

¹⁰ Inpatient Care refers to medical treatment that is provided in a hospital or other facility, and requires at least one overnight stay.

¹¹ Ambulatory Care includes diagnosis, observation, treatment, and rehabilitation that are provided on an outpatient basis.

¹² Primary Care refers to health care professionals who act as a first point of consultation for patients, and involves the widest scope of health care: patients seeking to maintain optimal health, and patients with all manner of acute and chronic physical, mental and social health issues, including multiple chronic diseases.

¹³ The definition of TBI is from multiple sources, including “Types of Brain Injury,” Brain Injury Association of America, October 15, 2008; and “Force Health Protection and Readiness Quick TBI and PTSD Facts,” Force Health Protection and Readiness, October 15, 2008.

¹⁴ The definition of PTSD is from multiple sources, including “Force Health Protection and Readiness Quick TBI and PTSD Facts,” October 15, 2008; and Jessica Hamblen, PhD, “What is PTSD?” National Center for PTSD, U.S. Department of Veterans Affairs, October 15, 2008.

TBI and PTSD health care services are provided by the Naval Hospital at Camp Lejeune and various civilian TRICARE network providers in the local community. TBI services include the following: Neurology, Neuropsychiatry, Speech Therapy, Occupational Therapy, Vestibular Rehabilitation, Physical Therapy, Cognitive Therapy, Pain Management, Acupuncture, Audiology, Mental Health, Biofeedback and Otolaryngology. PTSD services are provided by the Naval Hospital's Mental Health Department at the hospital, as well as the Central Intake and Referral Center and the Deployment Wellness Center that are both located on the Camp Lejeune installation. Additionally, the Naval Hospital's Substance Abuse Rehabilitation Program (SARP) is used to provide services for both TBI and PTSD patients who may have problems associated with substance abuse.

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**Part I -
Noteworthy Practices**

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Observation A. Noteworthy Practices for the Wounded Warrior Battalion – East

At the time of our assessment, we observed three noteworthy practices that WWBn-East had instituted with respect to providing quality services for recovering Marines. Those initiatives included:

- A.1.** The 9-Block Meeting¹⁵ allowed the Warrior’s Recovery Team¹⁶ to identify a recovering Marine’s need and develop an individualized course of action, which helped to facilitate their recovery and transition.
- A.2.** The leadership at WWBn-East was actively involved in screening non-military organization requests for visits to Warriors, which may result in limiting those visits that negatively affect a Warrior/or the Battalion’s environment.
- A.3.** The leadership at WWBn-East was supportive of activities that positively impact Warrior Transitions, however, given the constraints of Camp Lejeune’s isolated location, there were limitations in availability of meaningful programs.

We observed these three initiatives implemented at the WWBn-East and believe that these initiatives, as discussed below, have already improved and will continue to progressively improve and enhance the recovery process for Marines and their transition from the Camp Lejeune Battalion.

These noteworthy practices may be applicable for utilization at other U.S. Marine Corps Wounded Warrior locations and should be considered for prompt implementation. We plan to identify other noteworthy practices in a summary report, after all field assessments are completed, that the Services should consider for implementation throughout all of the Wounded Warrior units in the military, as appropriate.

¹⁵ WWBn-East held weekly 9-Block Meetings to highlight Marine Recovering Service members who may have issues that are worthy of extra attention from the command.

¹⁶The Recovery Team also known as the Outreach Task Force, are members involved in the overall care and management of a recovering Marine.

A.1. 9-Block Meeting

WWBn – East utilized their “9-Block” meeting to ensure that members of a Warrior’s recovery team were able to freely discuss potential and identified concerns that could adversely affect a Warrior’s recovery and transition. As a result, the recovery team was able to develop an individualized course of action to address each Warrior’s needs to better facilitate his or her transition.

A.1. Background

Department of Defense Instruction 1300.24, “Recovery Coordination Program,” December 1, 2009, established policy, assigned responsibilities, and prescribed uniform guidelines, procedures, and standards for improvements to the care, management, and transition of recovering Service members (RSM) across the Military Departments.

Accordingly, this instruction defined the requirements for a recovery plan as “a patient-centered plan prepared by a Recovery Team, recovering Service member, and family with medical and non-medical goals for recovery, rehabilitation, and transition, as well as personal and professional goals, and the identified services and resources needed to achieve the goals.”

Furthermore, the instruction identified the roles and responsibilities of a recovering Service member’s Recovery Team. Specifically, the policy required the members of a Recovery Team to collaborate with the Recovery Care Coordinator (RCC) and other Recovery Team members to develop the comprehensive recovery plan; evaluate its effectiveness in meeting the recovering Service member’s goals; and readjust as necessary to accommodate the Service member’s changing objectives, abilities, and recovery status.

The following individuals were identified by the Wounded Warrior Regiment as key members of a Warrior’s Recovery Team: Marine Commander, Section Leader and Platoon Sergeant, Recovery Care Coordinator, Family Support Advocate (Family Readiness Officer/Family Support Coordinator), Medical Case Manager (or medical representative) and Limited Duty Coordinator. Additional members, depending upon the case under review, included: Veteran’s Affairs and Military Services coordinators, Physical and Occupational Therapists, other medical representatives (Primary Care Manager, Licensed Clinical Care Consultant, and Mental Health Providers), Chaplain, and S-1 (Personnel) representative.

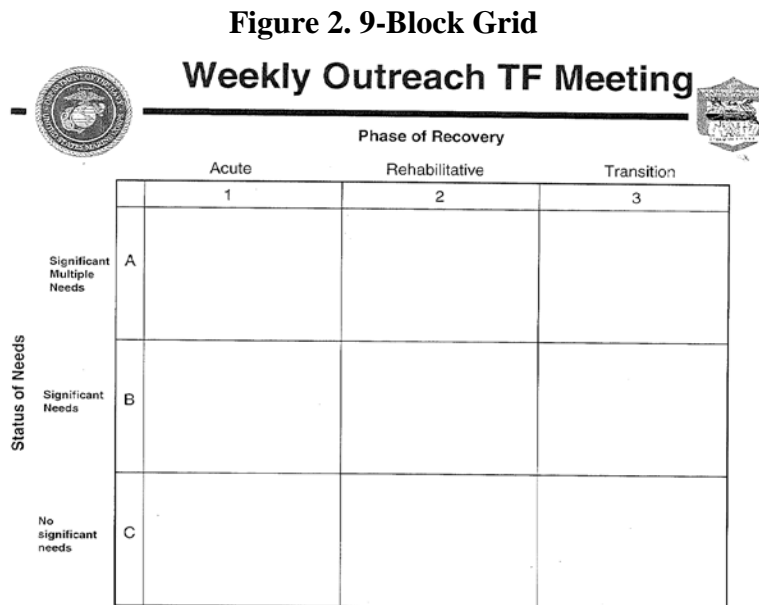
The Wounded Warrior Regiment identified the need for these key team members to participate in Recovery Team meetings to ensure that all personnel involved in the recovery and transition of a Warrior worked in the best interest of the Marine, given the Marine’s full medical and non-medical profile. The frequency of the Recovery Team meetings depended on the battalion or detachment location and patient load. At the meetings, the Recovery Team:

- discussed newly arrived Warriors;
- addressed, evaluated, and reevaluated crisis cases and made recommendations for action
- discussed high visibility cases

A.1. Discussion

According to the WWBn-East staff, weekly meetings of the Recovery Team were instituted by a prior Battalion Commander. One senior WWBn-East staff member lauded these meetings as a positive step towards helping the Battalion “get their arms around” those Warriors that needed extra attention from the Battalion.

Initially, the Recovery Team was called the “Outreach Task Force;” however, their meetings were eventually referred to as “9-Block” meetings due in part to the Battalion’s use of a 9-block grid¹⁷ which was used to identify and prioritize the needs of “high risk” Marines. An example of the 9-Block grid that was used during these meetings is shown in Figure 2.



When asked to explain the criteria used to identify “high risk” Warriors, a WWBn-East staff member explained that there were no written criteria or formulas; instead it was more of a “gut feeling” that a Warrior needed extra attention from the Battalion or Company. Consequently, the Warrior was identified to be included on the 9-Block grid and therefore was subject to discussion during the 9-Block meeting. The staff member added that with the new Battalion Commander, all Battalion processes and procedures, including those associated with the 9-Block meeting, were under review and would be formalized in written guidelines and standard operating procedures.

¹⁷ Description of 9-Block format: “Status of Needs” indicates varying degrees of needs (vice wants) of a Warrior or family that cannot be satisfied without intervention (e.g. Financial aid due to hardship, legal assistance, housing and transportation needs, child care and welfare issues, mental health intervention, among others.) “Phases of Recovery” identify where a Warrior is at in their transition (e.g. Acute – Inpatient or outpatient with a terminal illness; Rehabilitative – Progressed to physical therapy, or is in remission (cancer) in an outpatient setting; Transition – assigned to a Physical Evaluation Board.

During our site visit, we observed a 9-Block meeting, which was chaired by the WWBn-East Executive Officer and included representatives from all levels of the organization involved with the recovery and transition of the Warriors at Camp Lejeune. 9-Block Representatives are listed in Table 3.

Table 3. 9-Block Representatives

Wounded Warrior Battalion - East	Company Staff	Medical Representation
Battalion Sergeant Major	Company Commanders	Medical Case Management Advisor
Battalion Commanding Officer and/or Battalion Executive Officer	Company First Sergeant	Licensed Clinical Consultant (WWBn-East)
Battalion Chaplain		Director for Business Operations (Naval Hospital)
Family Support Coordinator		Medical Case Managers (Naval Hospital)
Recovery Care Coordinators		Medical Board Clerk

The Medical Case Management Advisor (MCMA) prepared the 9-Block chart prior to the meeting and placed the name of high risk Warriors in the appropriate block based on their phase of recovery and level of need. Each Warrior whose name was on the grid was discussed during the meeting to ensure that all staff members present were aware of the status of that Warrior's recovery and transition (e.g. pending medical appointments, and medical evaluation board progress). Time was also spent discussing possible problems or concerns that could affect the Marine or their family, thus adversely affecting their transition (e.g. relationship difficulties, financial concerns, to name a few.) During these discussions, possible actions and/or solutions were identified which would assist the Warrior and/or their family during their transition.

Participants in the meeting were knowledgeable of the individual cases, and discussions appeared open and professional. Upon the conclusion of each discussion, there appeared to be a clear direction as to whether any action was necessary to assist the Warrior, and who had the responsibility for the action, whether it was someone from the Battalion, Company, Naval Hospital or an outside organization, such as a Veterans Service Organization. The 9-Block grid not only served as a tool to identify Warriors who needed attention, but it also identified the recommended level of outreach and support needed from Battalion personnel as identified in Figure 3.

Additionally, all newly arrived Warriors were automatically entered into the 9-Block grid for at least a week, giving the Warrior time to acclimate to the Battalion, and also giving the staff time to become familiar with the Warrior's needs.

Figure 3. 9-Block Meeting Format
Wounded Warrior Battalion East
Prioritization of Needs Classification Matrix: “9-Block”

Status of Needs		Phase of Recovery		
		Acute	Rehabilitative	Transition
		1	2	3
Marine capable of managing and resourcing all family and personal needs	Significant Family AND Personal Needs A	-RCC outreach: every week (min) -Call Center outreach: none -FSC contact: twice per month -Command Group and Chaplain outreach – priority 1	-RCC outreach: every week (min) -Call Center outreach: twice per month -FSC contact: twice per month -Command Group and Chaplain outreach – priority 3	-RCC outreach: every week (min) -Call Center outreach: twice per month -FSC contact: twice per month -Command Group and Chaplain outreach – priority 4
	Significant Family OR Personal Needs B	-RCC outreach: every week (min) -Call Center outreach: none -FSC contact: twice per month for family needs -Command Group and Chaplain outreach – priority 2	-RCC outreach: every week (min) -Call Center outreach: twice per month -FSC contact: twice per month for family needs -Command Group and Chaplain outreach – priority 5	-RCC outreach: every week (min) -Call Center outreach: twice per month -FSC contact: twice per month -Command Group and Chaplain outreach – priority 8
	C	-RCC outreach: twice per month -Call Center outreach: once per month -FSC outreach: as needed -Command Group and Chaplain outreach – priority 6	-RCC outreach: once per month -Call Center outreach: twice per month -FSC contact: as needed -Command Group and Chaplain outreach – priority 7	-RCC outreach: once per month -Call Center outreach: once per month -FSC contact: as needed -Command Group and Chaplain outreach – priority 9

Finally, we noted during our observation of the 9-Block meeting that all participants were extremely sensitive to Health Insurance Portability and Accountability Act (HIPAA)¹⁸ related concerns. A senior WWBn-East official explained that all staff had been HIPAA trained. We also noted that the WWBn-East Executive Officer chairing the meeting provided a warning, both at the beginning and end of the meeting, that all personal and health information discussed during the meeting should be safeguarded and not shared with those outside of the room. All paperwork that contained personal or health-related information was shredded upon the conclusion of the meeting.

A.1. Conclusion

The 9-Block meeting utilized by the WWBn-East was a multidisciplinary meeting of military leaders and health services personnel designed to discuss “high-risk” Warriors assigned to the Battalion. During our discussions it was identified that there was no written criteria or formulas that helped identify those “high-risk” Warriors. Use of the 9-Block grid however, allowed the Battalion and other leaders to identify Warriors according to their phase of recovery and whether they had significant needs that required additional interventions. Additionally, these meetings served as a mechanism to develop and implement actions that helped to promote effective transitions for Warriors.

Once institutionalized with written standard operating procedures, it is our opinion that WWBn-East’s 9-Block meeting could be utilized by other Wounded Warrior units as a method to

¹⁸ Health Insurance Portability and Accountability Act (HIPAA), is a US law designed to provide privacy standards to protect patients’ medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

identify and discuss Warriors who may need extra attention and intervention, which could result in a smoother transition back to duty or to the civilian community.

A.1. Recommendation

We recommend that the Wounded Warrior Regiment formalize throughout all Wounded Warrior Battalions and detachments a forum such as WWBn-East's "9-Block" meeting to ensure that there is a clear plan among the Recovery Team members to address the needs of "high-risk" Marines.

A.2. Screening Requests to Visit Warriors

WWBn – East developed a process to review and screen requests by non-military organizations that desired to visit Warriors. As a result, the WWBn-East reduced the potential for exploitation of Warriors, therefore avoiding negative consequences to morale, and the overall health and welfare of the Warriors.

A.2. Background

The Wounded Warrior Regiment in Quantico, VA has a Charitable Giving Office that coordinates with a broad range of charitable groups and private individuals who provide a range of financial and in-kind support (i.e. concerts, athletic outings, family activities, or community based initiatives) and services to recovering Marines and their families. This office is responsible for:

- Investigating donors to ensure reliability and identify non-prohibited sources
- Coordinating with legal officers on offers of gifts and/or donations
- Serving as a conduit and coordinator for many of the Regiment's special events and programs

The following organizations and groups are examples of entities and/or individuals that have been interested in providing support to Wounded Warriors:

- Grass root organizations (Churches, Scout organizations, companion dogs, community task forces)
- Entertainment Industry (Individual artists)
- Corporate America (Fortune 500 Companies, former Marines)
- Federal/DoD/Interagency (White House, Congress, Veterans Affairs, Labor, FBI)
- Professional Athletics (NASCAR, Giants, Capitals, Tiger Woods Foundation, etc.)
- Civic Organizations (Rotary, Veteran's Services Organizations, Elks, etc.)

A.2. Discussion

There is a high level of public interest in offering support for Service members who are injured in Operation Iraqi Freedom and Operation Enduring Freedom. The WWR staff encouraged recovering Marines to take advantage of these opportunities, once they were cleared by the Regimental Charitable Giving Office. Additionally, they believed that these activities would provide an opportunity for recovering Marines to leave the hospital or barracks environment, reengage with their local communities, and spend quality time with their families and fellow Marines.

At times, organizations and/or individuals contacted WWBn-East directly with requests to visit Wounded Warriors present at the Camp Lejeune location. In response, the command established a procedure whereby these requests were screened to ensure that they were appropriate and did not exploit any Marines.

The command team explained that outside agencies sometimes do not have the best interests of the Warriors at heart. Warriors complained about the “petting zoo” environment created when certain non-profit agencies came to visit. Organizations would call in looking for “visibly wounded” Marines (e.g. burn victims, amputees) to participate in their events. A few agencies had expressed disappointment that TBI patients did not “look the part.” Therefore, the command implemented a screening process to review outside requests and ensure that wounded Marines would not be exploited. For example, visits by high profile individuals, members of Congress, local businessman, and other community personnel created chaos in the barracks and a division in the unit over visits to the barracks.

The WWBn-East Chaplain also reiterated wounded Marines’ complaints of a “petting zoo” environment in the barracks. Many times visiting non-military organizations wanted to see a “poster child” of a wounded Marine, and they would offer donations for selected personnel and not the unit as a whole. The Chaplain explained that the command had to get involved to limit these occurrences. In order to promote a positive environment, several groups had to be kept out of the barracks.

A.2. Conclusion

The WWBn-East practice of screening requests for visits to Warriors ensured that the WW Bn-East leaders were involved in safeguarding the Warriors from potential outside negative influences. By screening outside requests, the WWBn-East leaders were actively and responsibly protecting the Warriors assigned to the WWBn-East. It also appeared that the WW Bn-East leaders were reasonable and judicious in making the decisions to support requests for visits to the Warriors.

A.2. Recommendation

We recommend that the Wounded Warrior Regiment adopt policy similar to that established by Wounded Warrior Battalion-East regarding screening requests for visits to Warriors by non-military organizations to ensure consistent practices are applied at all levels.

A.3. Activities to Positively Impact Warriors Transition

WWBn – East provided meaningful programs of constructive activities to assist with Warriors’ transition. However, based on the physical location of Camp Lejeune, these opportunities were limited. Consequently, Warriors were limited in activities to positively impact their transition to civilian life.

A.3. Background

The U.S. Marine Corps defined that in campaign planning there are numerous Lines of Operation that must function together as one harmonious whole and the Lines of Operation must be the roads followed to meet the desired end result. As the Headquarters command for all Marine Corps matters related to the medical care and management of Wounded Warriors, the WWR adopted the Lines of Operation method to ensure Warriors were provided the leadership and opportunities needed to be successful.

The goal of the Lines of Operation is to integrate the Marine’s medical recovery process with productive and meaningful non-medical activities that strengthen the mind, body, spirit and family. Warriors are to be guided by caring and concerned leaders who encourage, counsel, and motivate them to establish personal and professional goals which are captured in their Comprehensive Transition Plan and which remain focused on their ability vice their disability. The Lines of Operation are as follows:

Table 4: Lines of Operation

Lines of Operation	Definition
Mind	Provide activities to improve the Marine’s self-worth, mental stability, a sense of purpose, and clarity of mind
Body	Strengthen the Marine’s body through physical activity and nutrition to develop life-long healthy habits
Spirit	Reignite the spark within the Marine by providing a sense of belonging, purpose, and pride and a renewed sense of self-confidence
Family	Encourage, nurture, and guide the Marine’s family through the recovery process and beyond

A.3. Discussion

The WWBn-East offered activities to Wounded Warriors supporting the Lines of Operation pertinent to “mind, body, spirit, and family.” The following programs were available to Warriors:

- Transition Center and Transition Assistance Management Program – resume preparation and resource counseling
- Veterans Foundation (COMPASS) Transitioning Program – included resume building and life skills classes; mock interviews mentored by industrial professionals
- One-on-one counseling with Department of the Navy Human Resources personnel – supported resume building, finding job opportunities

- Warrior Athlete Reconditioning Program

Our interviews revealed that while Warriors appeared to be seriously engaged in the various transition activities, some Warriors did not take full advantage of the programs available to assist them in transition. Additionally we noted that several individuals did not believe that enough effort was made to ensure that all Marines were engaged in structured activities that were in support of their transition goal. For example:

- One RCC commented that some Marines were viewed as “Couch potatoes or lounge lizards.” Additionally, they believed that these Marines needed more structured activities to keep them busy during the day. Specifically, he suggested that it would be helpful if there was a database of available jobs Marines could perform on base during their stay at WWBn-East.
- Several other RCCs also commented that many Marines needed to be connected with internships/jobs/careers that they wanted to do. The RCCs recognized the difficulty for jobs in the Jacksonville community, which was why having more job opportunities on base would be helpful. The Marines also needed true vocational rehabilitation programs.

We were told by multiple WWBn-East staff that the battalion commander had established “priorities of work” for wounded, ill, and injured Marines, which included: (1) medical appointments, (2) rehabilitation, and (3) free time. Additionally, they explained that battalion leadership did support work and school during duty hours, provided the Marine met their medical and rehabilitation appointments.

While we agree that the Battalion’s leadership was supportive of allowing a Marine to participate in work and/or school opportunities during duty hours, we found that this opportunity was limited in practice. For example, one platoon leader indicated that internships were available for Marines, however, it was up to the Marine to process the paperwork, noting it could be a long and complicated process. Furthermore, these leaders stated the demand was greater for more vocational opportunities, specifically internships, than were available.

Additionally, we found that the lack of meaningful transition activities may have affected the morale of some Wounded Warriors. Specifically:

- One RCC mentioned that it was a difficult balance for the Battalion to keep wounded, ill, and injured Marines engaged without them feeling like they are being “messed with,” and if they sit and do nothing, they end up feeling useless and their morale further declines. He did comment that the Warrior Athlete Reconditioning (WAR) Program was a good thing. However since it was mandatory several Warriors felt they were being “messed with,” which created some anxiety.
- All RCCs cited the prolonged medical evaluation board (MEB) and integrated disability evaluation system (IDES) process, stating that “idle hands” and lack of knowing when the Marine would separate negatively affected the entire transition experience. He

further remarked that the battalion had to work to “keep them engaged” while they were waiting for results of the medical board.

- During separate interviews with the RCCs, they stated that the barracks was a “sad place to be,” and that Marines, specifically junior Marines, did not know how to handle their “down time,” had low morale, and that they did not feel they were “part of a team” when assigned to the WWBn-East.

Battalion support staff explained that the Regimental commander was very focused on “transition,” noting that he wanted Marines to look to the future and to identify appropriate goals that would help them get where they wanted to go. Additionally, the Commander felt that it was the battalion’s responsibility to assist the Marine in working towards their individual goals.

Battalion staff were encouraged by the Battalion commander’s personal involvement in the review and approval of a Wounded Warrior’s 18 month transition plan. The staff explained that the transition plan was mandatory for Marines and consisted of not only the CTP, but an 18-month financial plan, a resume and three main goals. The 18-month financial plan was focused on the 18 months after separation, and according to the platoon leaders must be “solid” prior to going to the battalion commander for approval.

Furthermore, they identified the benefit of the Transition Center serving as a resource to help coordinate job fairs, assisting with resume writing classes, and employment opportunities for transitioning Marines.

We acknowledge that identifying and implementing beneficial Warrior activities that promote an effective transition to civilian life is challenging. However, we believe that all Warriors need to be engaged in constructive educational and career training activities to effectively use their time and assist in preparation to make a successful transition to civilian life.

A.3. Conclusion

The leadership at WWBn-East was supportive of activities that positively impacted Warrior Transitions, however, given the constraints of Camp Lejeune’s isolated geographical location, there were limitations in availability of meaningful programs. Warriors should be provided with meaningful activities including internships/clerkships, and educational opportunities suited to the individual needs of each Warrior, that will positively impact their transition from recovery through rehabilitation to community reintegration. For amplifying remarks by Warriors concerning this section, refer to Part III, Warrior Speak.

A.3. Recommendation

We recommend that the Commander, Wounded Warrior Battalion-East ensure each Warrior has a comprehensive program of constructive education and career training, tailored to individual Warriors’ needs and plans, in order to facilitate Warrior recovery and transition.

Observation B. Noteworthy Practices for the Naval Hospital Camp Lejeune

Naval Hospital Camp Lejeune leadership instituted four initiatives that we believe to be noteworthy practices. They are:

- B.1.** Equal Access to Care
- B.2.** Primary Care Manager Dedicated to the Battalion
- B.3.** Assignment of Warriors to Medical Case Managers
- B.4.** Co-location of Substance Abuse Rehabilitation Program (SARP) with Mental Health Resources

We observed these four initiatives implemented at the Naval Hospital and believe that they as discussed below, have already been beneficial and will continue to progressively improve and enhance the recovery process for Marines to enable a transition from the Camp Lejeune Battalion.

These noteworthy practices may be applicable for utilization at other U.S. Marine Corps Wounded Warrior locations and should be considered for prompt implementation. We plan to identify other noteworthy practices in a summary report after all field assessments are completed that the Services should consider for implementation throughout all of the Wounded Warrior units in the military, as appropriate.

B.1. Equal Access to Care

Warriors and support staff did not note any difference in access to medical care for Active Duty and Reservists. As a result, we found no indication that medical care delivery was provided unequally between Active Duty and Reserve Wounded Warriors.

B.1. Background

In May 2010, United States Senator Ron Wyden and Congressman Kurt Schrader contacted the Inspector General, Department of Defense concerning medical treatment entitlements available to the returning soldiers of the Oregon National Guard. They requested that we investigate this issue as well as the medical treatment entitlements for all Guard and Reserve soldiers at all Warrior Transition Units and mobilization and demobilization sites.

B.1. Discussion

At the time of our site visit to the WWBn-East at Camp Lejeune, there were 194 Active Duty Marines assigned or attached, with no activated Marine Corps Reservists assigned or attached. Between April 2007 and the end of our site visit, there have been a total of 10 Reservists that have transitioned through the WWBn-East.

While there were no reservists interviewed during our visit, several Warriors that we interviewed commented that they were unaware that Reservists were even assigned to the WWBn-East as patients. This suggests that from the perspective of the Warriors, there was no differentiation between Active Duty and Reserve, and as one Warrior stated, their access to care is “absolutely equal.” The data to completely prove or disprove this concern were not available from Naval Hospital Camp Lejeune and WWBn-East, but the lack of perception of such inequity by the service members themselves is a strong indicator that this was not an issue.

During several individual Warrior interviews, one Warrior stated “he hasn’t noticed any difference; he really can’t tell the difference between reservists and active duty, though, unless you ask them.” Another Warrior commented that “he couldn’t tell who’s reserve and who’s active duty anyway.” A different Warrior stated that “if you are in Wounded Warriors you should be treated the same as all others.”

During a family interview session, when asked if they felt there were any differences in access to medical care, the family member noted that they did not see any difference in care that was provided to combat injured versus non-combat injured Marines.

Finally, a group of Recovery Care Coordinators (RCCs) interviewed stated that there were no perceived differences in the care and treatment of personnel assigned to the WWBn-East. They noted that combat wounded, ill and injured were treated the same as non-combat wounded, ill and injured, or injured personnel and the RCCs felt that this is the way it should be since they are all Marines who require medical care and transition assistance with their new lives outside of the Marine Corps.

B.1. Conclusion

Overall, the Warriors that we interviewed stated that they received equitable access to medical care for the condition(s) that required their assignment or attachment to the WWBn-East. We believe that ongoing assessment of patient satisfaction metrics remains a qualifier to determining any change in the overall quality of care delivery for active duty versus reservists throughout the healthcare system.

B.1. Recommendation

We recognize equal access to care as a noteworthy practice that has already improved and will continue to improve and enhance the recovery process for Marines as they heal, recover, and transition.

B.2. Primary Care Manager Dedicated to the Battalion

Naval Hospital Camp Lejeune, identified a single healthcare provider as the Primary Care Manager for all Warriors attached to the WWBn-East. As a result, Warriors were able to establish a relationship with one healthcare provider who may have helped to improve continuity of care and access to specialty care.

B.2. Background

A primary care manager (PCM) is either a military or civilian health care provider (e.g. physician, physician's assistant, or nurse practitioner) who is the medical point of contact and healthcare advocate for the Warrior. They provide primary oversight and continuity of healthcare and are to ensure the level of care provided is of the highest quality. They are the gateway to all specialty care (such as behavioral health specialists or orthopedic surgeons) and they coordinate with other physicians to ensure that the Warriors are getting the treatment that they need.

Continuity of care is a process by which the Warrior (patient) and physician are cooperatively involved in ongoing health care management toward the goal of high quality, cost-effective medical care. The Assistant Secretary of Defense (Health Affairs) "Policy Memorandum Implementation of the 'Patient-Centered Medical Home' Model of Primary Care in MTFs," September 18, 2009, is an established model of primary care that improves continuity of care and enhances access through patient-centered care and effective patient-provider communication.

One of the core principles of this model is that a patient has a consistent relationship with their health care provider, who delivers first contact, continuous, and comprehensive care.

B.2. Discussion

Wounded Warriors attached to WWB-East who receive their medical care at Naval Hospital Camp Lejeune were enrolled with a single individual health care provider who was responsible for their primary care. This provider, also referred to as a Warrior's PCM, was an Internal Medicine Physician,¹⁹ a retired Naval officer with several years of experience in caring for and treating Marines with war-related illnesses and injuries at Camp Lejeune.

The Commander, Naval Hospital Camp Lejeune briefed that recently they had dedicated a PCM for the WWBn-East Warriors, and that it was working out well because the case managers have a single "funnel" for information, instead of having to call multiple providers and specialty providers working with each Warrior.

The PCM mentioned that in addition to his time in the battalion he also spent time fostering an interdisciplinary approach with other providers (e.g. mental health, pain management, and specialists such as neurology and orthopedics).

¹⁹ Doctors of internal medicine focus on adult medicine and have had specialty study and training focusing on prevention and treatment of adult diseases.

During our interview with the Medical Case Managers (MCMs) they indicated that having the PCM in the battalion had made a big difference in access to primary and specialty care.

Another WWBn-East senior official noted that having a dedicated PCM resulted in a positive change for the unit, and that the PCM had “done wonders at cleaning up the over-medicated Marines.”

B.2. Conclusion

The implementation of a dedicated physician serving as the Warriors PCM provided medical continuity of care for Warriors. This practice streamlined support for the Warriors’ recovery and served as a single point of reference for additional support to the Warriors and the battalion. This practice also ensured comprehensive oversight of medications prescribed to Warriors from all medical provider sources, thus potentially mitigating the risk of overmedication.

B.2. Recommendation

We recommend that the Wounded Warrior Regiment and Department of the Navy Bureau of Medicine and Surgery work together to ensure that there are dedicated primary care managers throughout all Marine Wounded Warrior sites to ensure primary care oversight, continuity and comprehensive medical care to the Warriors as they continue to recover, rehabilitate and transition.

B.3. Assignment of Warriors to Medical Case Managers

The Naval Hospital Camp Lejeune's lead MCM for Warriors at WWBn – East assessed each Warrior upon arrival and assigned individual Warriors to a specific MCM and platoon. As a result, the most capable MCMs were assigned to facilitate each Warrior's medical and transition needs.

B.3. Background

Case Management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet complex health care needs through communication and available resources to promote quality, cost effective outcomes.

The Navy does not have a standard fixed ratio that it uses to determine the number of patients per assigned case manager. However, the Department of the Navy Bureau of Medicine Instruction 6300.17, "Navy Medicine Clinical Case Management," November 23, 2009, followed the DoD TRICARE Medical Management Guide recommendations that the caseload for case managers ranges from 10 to 50 patients per case manager depending on acuity. Acuity levels are described in the ASD(HA) Directive Type Memorandum 08-033, "Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the Military Health System," August 26, 2009. Specifically, the acuity is based on the number of interventions that a case manager may be required to perform and the frequency of follow-up with the patient. Possible interventions include activities such as medication counseling, arranging for durable medical equipment,²⁰ and communicating with and educating family members, among others.

B.3. Discussion

The Naval Hospital lead case manager used a deliberate process to assign an incoming Warrior to a specific case manager. Specifically she considered the experience and skill set of the case manager and the possible needs of the Warrior.

The experience level of the five MCMs identified to manage Warriors' care ranged anywhere from 2 to 10 years. Some had nurse case management experience while others were Intensive Care, or Emergency Services/Trauma nurses; several had experience working for private and contract healthcare agencies and Medicare/Medicaid. A large number of MCMs had military experience or exposure to the military culture.

²⁰ Durable Medical Equipment is reusable medical equipment that must be ordered by a doctor, a nurse practitioner, physician's assistant, or clinical nurse specialties to be used by individuals in their home. This equipment must be required to improve the quality of life or be a medical necessity for home use. Examples include: wheelchairs, oxygen equipment, crutches, hospital beds, patient lifts, power scooters and nebulizers.

Training included completion of case management core competencies to determine competency and critical thinking levels; training in Armed Forces Health Longitudinal Technology Application (AHLTA);²¹ and Composite Health Care System (CHCS);²² and attending in-services²³ and/or conferences for specific topics such as TBI and PTSD. In addition, all MCMs completed the Military Health System online training modules and attended a 2-week DoD orientation specific to Wounded Warrior care and transition. Furthermore, some MCMs were assigned to support specific areas such as medical evacuation,²⁴ medical evaluation board²⁵ process, orthopedics, TBI services and Mental Health. The MCMs also had the authority to initiate referrals, which aided the provider staff.

During two different group interviews with the MCMs, they explained that each Marine was screened by the Case Management Division Officer before being assigned to the appropriate MCM, and that the Lead MCM determined which MCM was assigned the next incoming Marine. One MCM added that the assignment process was based on Warrior acuity and skill mix of the MCM, as well as the platoon to which they were assigned.

Additionally, during our interviews with the platoon leaders, several commented that effectiveness of communications had greatly increased since assignment of MCMs to the Platoons. One platoon leader stated that having the MCMs make the decision where the Marine would be assigned based on acuity and risk was a good practice. Furthermore, the platoon leader explained that he met weekly with the MCM prior to the 9-Block meetings to review one hundred percent of the assigned Wounded Warrior Marines.

Finally, the MCM advisor and licensed clinical consultant both commented that they had observed and experienced improved communications among leadership and support staff by assigning the MCMs with the Platoon in the battalion. As a result, they were exploring the options of assigning RCCs to the Platoons to be better advocates for the Warriors.

²¹ Armed Forces Health Longitudinal Technology Application (AHLTA) is the clinical information system that generates and maintains a lifelong, computer-based outpatient record for every Soldier, Sailor, Airman, and Marine; their family members; and others entitled to DoD military care who receives care in a military treatment facility.

²² Composite Health Care System (CHCS) is DoD's initial health record system, now used primarily for ordering laboratory tests, retrieving lab results, authorizing radiology procedures, prescribing medications and scheduling appointments.

²³ In-services are geared towards enriching knowledge, building on skill-set, and keeping abreast with clinical research and medical practices. Programs are done through self-study, group-study, class room and one-to-one.

²⁴ Medical evacuation is defined as to transport a patient to a place where medical care is available.

²⁵ The medical evaluation board (MEB) is part of the disability screening process; on the basis of medical examinations and the service member's medical records, an MEB identifies and documents any conditions that may limit a service member's ability to serve in the military

B.3. Conclusion

The decision to assign a newly arrived Warrior to a specific MCM helped to facilitate the Warrior's treatment, recovery and transition. Additionally, by assigning MCMs with specific platoons resulted in improved overall communication among support staff and Warriors, unity of effort and continuity of care which is crucial to supporting individual Warrior needs for healing and transition.

B.3. Recommendation

We recommend that the Commander, Wounded Warrior Regiment formalize throughout all Wounded Warrior Battalions and detachments processes for assigning Medical Case Managers to Platoons as a method to improve continuity of care and enhance communication in supporting Warriors' needs for healing and transition.

B.4. Co-Location of Substance Abuse Rehabilitation Program with Mental Health Support from the Deployment Wellness Center

Mental Health practitioners from the Deployment Wellness Center were co-located with the Substance Abuse Rehabilitation Program where Warriors received evaluation and treatment for substance abuse-related conditions. As a result, mental health support was readily accessible to support substance abuse counselors and enhance Warrior recovery. Furthermore, the accessibility of the mental health providers potentially helped reduce fear and apprehension among Warriors in need of mental health services.

B.4. Background

As a DoD and Navy Medicine mandated program, the Deployment Health Center supported commanders and their medical assets/components with medical screening to identify any emerging medical or mental health concerns due to post-deployment. Physical and psychological health screening must be completed on all military service members within 30 days of return from deployment, then between 90 and 180 days of returning to identify any need for mental health evaluation and treatment. All returning Warriors were required to complete the screening form prior to scheduling an appointment with a Deployment Wellness Center provider.

The primary objectives of the Substance Abuse Rehabilitation Program (SARP) were to promote readiness, health, and wellness through the prevention and treatment of substance abuse; to prevent the negative consequences of substance abuse to the individual, family, and organization; to provide comprehensive education and treatment to individuals who experience problems attributed to substance abuse; and to return identified substance abusers to unrestricted duty status or assist them in their transition to civilian life, as appropriate. The program also provides an eight day program designed for patients diagnosed with alcohol abuse and a three-week program for patients diagnosed with alcohol dependence, residential treatment and continuing care services for all active duty personnel.

B.4. Discussion

U.S. Service members may be reluctant to seek medical assistance for mental health conditions, due in part to the perceived negative stigma associated with receiving mental health services. A Defense Department study looking at combat troops returning from Iraq found that Soldiers and Marines who needed counseling the most were least likely to seek it, as many as sixteen percent of the troops questioned admitted to symptoms of severe depression, Post Combat Stress Disorder and other problems. Of those, six out of ten believed their leaders would treat them differently and that fellow troops would lose confidence in them. As many as sixty-five percent said they would “be seen as weak.”

Naval Hospital Camp Lejeune has made a conscious effort to ensure that mental health services are available in an unobtrusive way. Specifically, they have mental health providers that are available in the Deployment Health Center where Marines complete their post-deployment health assessments. Additionally, the hospital has embedded mental health providers in this same building where the SARP is located.

A senior Naval Hospital Camp Lejeune official identified the co-location of the SARP with the Deployment Wellness Clinic as one of their most recent successes. He acknowledged that the setup in which SARP was physically located with mental health providers of Deployment Health was optimal. Specifically, the benefit of having the mental health providers physically co-located with the SARP counselors and the improved communication between the two services had resulted in improved Warrior care.

For example, each mental health provider in the clinic was available for a one-hour crisis intervention every day, and if a Warrior participating in the SARP was determined to need mental health services, a mental health provider would be immediately available.

Finally, the official explained that the physical set-up of the clinic helped to mitigate a perceived negative stigma of individuals seeking mental health support. If SARP counselors identified a Warrior's need for mental health services, the Warrior could simply shift to another provider within close proximity for those services without others outside the building knowing where they were. The official further explained this would not be accomplished if mental health support was located in another building, especially, if that clinic was labeled "Mental Health Clinic."

B.4. Conclusion

The co-location of mental health services and SARP in the Deployment Wellness Center was reported as a positive change for the mental health care provider staff and Warriors they support. By sharing mental health care services and substance abuse counseling resources, co-location has enhanced the healing and recovery of Warriors needing mental health care support.

B.4. Recommendation

We recommend that the Navy Bureau of Medicine and Surgery consider the co-location of mental health providers and Substance Abuse Rehabilitation Program units as a preferred practice and develop policy to establish this practice in other Naval facilities supporting Wounded Warrior units.

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Part II - Challenges

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Observation C. Challenges for the Wounded Warrior Battalion - East

We identified three challenges that should be addressed by the Battalion's leadership and staff to help ensure the most successful and effective support for the care, healing, and transition of Wounded, Ill and Injured Marines. These challenges are identified as follows:

- C.1. Warrior's Comprehensive Transition Plans**
- C.2. Staff Training in Support of Warrior's Recovery and Transition**
- C.3. Abuse of Illegal Drugs and Prescribed Medications**

We believe that addressing these challenges will increase the effectiveness of the WWBn-East leadership and staff in providing quality and timely care and services that facilitate Warrior recovery and transition.

C.1. Warriors' Comprehensive Transition Plans

Warriors did not appear to have ownership of their Comprehensive Transition Plan (CTP) as a tool to help them identify their individual goals and actions needed to guide them as they transition from recovery and rehabilitation to community reintegration. Consequently, Warriors may have been at risk of not accessing the full benefits of tools and resources available to help them fulfill their transition goals.

C.1. Background

Department of Defense Instruction 1300.24, "Recovery Coordination Program," December 1, 2009, established policy, assigned responsibilities, and prescribed uniform guidelines, procedures, and standards for improvements to the care, management, and transition of recovering service members (RSM) across the Military Departments.

This instruction defined a recovery plan as "a patient-centered plan prepared by a [recovery team, recovering Service member], and family or designated caregiver with medical and non-medical goals for recovery, rehabilitation, and transition, as well as personal and professional goals, and the identified services and resources needed to achieve the goals."

Furthermore, the instruction identified the roles and responsibilities of a recovering Service member's Recovery Team. Specifically, the policy requires the members of a Recovery Team to:

- Collaborate with the Recovery Care Coordinator (RCC) and other Recovery Team members to develop the comprehensive recovery plan, evaluate its effectiveness in meeting the recovering Service member's goals, and readjust it as necessary to accommodate the Service member's changing objectives, abilities, and recovery status.

The United States Marine Corps Wounded Warrior Regiment Handbook, December 2010, described the Marine Corps' Recovery Coordination Program as a program to help recovering Marines and their families as they transitioned through the various phases of recovery. RCCs are identified as a fundamental component of the program who along with Section Leaders, define the Warrior's individual goals for recovery, rehabilitation and reintegration and identify the services and resources needed to achieve these goals.

The CTP was the tool used by RCCs to coordinate a Warrior's and their family's care. The CTP was based upon information from the Warrior's recovery needs assessment, which was developed with the help of the RCC taking into consideration various components such as employment, housing, financing, counseling, family support, the disability evaluation process, among others. The WWR described the CTP as "owned by the Marine" and reflected their medical and non-medical goals and milestones from recovery and rehabilitation to community integration. In further clarification, the Regiment referred to the CTP as a "life map" for the recovering Marine.

C.1. Discussion

The CTP was designed to provide “one stop shopping” whereby a Marine could find resources to meet their immediate and most apparent needs. It was also designed to establish individual goals, or a desired end-state. In doing so, the CTP notified the various programs available to the Marine so that the Marine can utilize them to strengthen mind, body, spirit and family. The RCCs were responsible for the oversight of the CTP and viewed it as a living document that changed as the goals and needs of the Warrior changed.

Our interviews with Warriors and with Battalion support staff revealed that there was very little understanding of and support for the CTP. Specifically, when we asked Warriors about their CTP and their involvement with preparing and updating their Recovery Plan, they stated that they had not heard of the term “CTP” or “Comprehensive Transition Plan,” and did not know to what it referred to.

Upon further questioning, Warriors did not associate the term “CTP” or “Comprehensive Transition Plan” with the Battalion’s efforts to facilitate transition. However, when specifically asked about goals and future transition plans, the Warriors acknowledged that their RCCs had guided them through a process of identifying their goals and job interests and opportunities for transition, as well as provided assistance in working through their 18-month financial plan. The transition plan was mandatory for Marines and consisted of not only the CTP, but an 18-month financial plan, a resume and three main goals (as previously discussed in A.3., Activities to Positively Impact Warriors Transition). The 18-month financial plan was primarily focused on the 18 months after separation. One Warrior commented about the 18-month financial plan, “it was a real eye-opener” when he listed his finances/expenses on paper, it looked much different than the picture he had in his mind.

Our interviews with Platoon Leaders reveal that they did not have an understanding of the CTP, nor were they specifically involved with helping the Warrior with their CTP. In fact, similar to Warriors, several Platoon Leaders did not recognize the term “CTP” or “Comprehensive Transition Plan.” Instead, several platoon leaders thought we were referring to the 18-month financial plan, which they acknowledged was a valuable tool for both Warriors and their families.

WWR regulations specify that the RCC has responsibility to assist Warriors in the development of their CTP. Our interviews with RCCs at WWBn-East identified challenges and detractors as they worked with the CTP tool. Specifically, the RCCs believed there was more emphasis in the Battalion on completing the CTP than focusing on the content of the plan.

For example, the RCCs generally stated that the CTP was “a joke,” and that it was “too much administrative work.” They also viewed the CTP as an “after-action document” rather than a living plan that drove Warrior transitions forward, which of course made it less useful.

C.1. Conclusion

The CTP had recently been implemented within the WWBn-East and was being utilized by the RCCs as required by WWR regulations. However, the majority of Warriors did not associate the name of the CTP with the ongoing work that the RCCs had done to guide them through the process of identifying their goals and job interests as part of their personal recovery and transition plan. Additionally, the Platoon Leaders were not committed to, or engaged in, the CTP process.

The Warriors did not themselves appear to have ownership for, or engagement with their CTP. Rather RCCs seemed to be the ones filling them out for the Warrior. As a result, Warriors did not fully understand the relationship between the CTP and their recovery goals and how this plan could affect their transition. For amplifying remarks by Warriors concerning this section, refer to part III, Warriors Speak.

C.1. Recommendation, Management Comments, and Our Response

C.1. We recommend that the Commander, Wounded Warrior Battalion-East develop procedures and training for Warriors to ensure that they are active participants in the development of their Comprehensive Transition Plan, and that it is individually tailored and effective in fulfilling their transition goals.

Wounded Warrior Battalion-East Comments

The Commanding Officer, Wounded Warrior Battalion-East concurred with comment to our recommendation. The Commanding Officer explained that process changes have been put into place to improve usage and awareness of the Comprehensive Transition Plan (CTP), now referred to as the Comprehensive Recovery Plan (CRP). The Commanding Officer reported that, as of December 2011, the United States Marine Corps Recovery Care Coordinator Program was the first service program to have fully implemented the Recovery Coordination Program Support Solution (RCP-SS). The RCP-SS is a technology tool that houses the CRP, and provides a standard CRP across the Wounded Warrior Regiment and allows a CRP to be easily transferred from one Recovery Care Coordinator (RCC) to another. Additionally, since April 2011, the RCC Program has implemented a robust training program to provide RCCs with the tools they need to properly document a Marine's needs, goals, and required actions in the CRP. The CRP is written in the Marine's own words encouraging buy-in and follow-through. The RCCs, Section Leaders, and Wounded Warrior Battalion transition staff work closely to ensure that Marine's goals are realized and that efforts are coordinated. Furthermore, the Commanding Officer stated that since August 2011, the RCC Program has implemented a quality assurance program to ensure consistent CRP development and documentation.

Our Response

The Commanding Officer's comments are responsive and the actions meet the intent of the recommendation. No further action is required.

C.2. Staff Training in Support of Warrior’s Recovery and Transition

WWBn-East personnel involved in the medical care and management of Wounded Warriors desired additional medical training about topics such as PTSD, TBI, and the medical board process, among others. Without this training, personnel working with Wounded Warriors were at risk of not having the requisite knowledge to effectively assist the Warriors to heal and transition.

C.2. Background

Those responsible for the medical care and management of Wounded Warriors were required to attend training specific to understanding the Warrior’s recovery and transition process.

According to the Department of Defense Instruction, 1300.24, “Recovery Coordination Program (RCP),” December 1, 2009, all recovery team members (RCC, MCM, PCMs) shall complete military department –specific training prior to independently assuming the duties of their positions, and comply with continuing education requirements.

The Instruction specified that as part of the RCCs responsibilities, they shall complete uniform core training conducted by Wounded Warrior Care and Transition Policy, and also Military Department-specific training conducted by the responsible Wounded Warrior program prior to assuming the duties of their positions.

C.2. Discussion

Training of the recovery team members involved in the medical care and management of Warriors was critical to the transition process. Recovery team members were integral in moving the Warrior forward in their transition. To do so, it was essential that they received education and training beyond the minimum mandatory training to understand their job. They needed additional training so that they could better understand the medical factors potentially impeding a Warrior’s transition progress, and the resources that could be mobilized to address them.

Our interviews with Battalion RCC support staff identified several opportunities for improvement in its training program for them. Specifically, RCCs described the following:

- RCCs training consisted of DoD-level training and Marine Corps-specific training upon assuming their respective duties. They expressed that the 12-day training was generally adequate. The first week focused primarily on service related topics, to include VA, Department of Labor and sexual assault training; while the second week was more RCC-specific. However, they believed the training would have been more helpful after they had been in the position for a month or two.
- Quarterly update training on programs and resources available to Wounded Warriors would also be helpful. RCCs noted that relevant information pertaining to Warrior recovery and transition was constantly changing and having an update as to what was currently available would help them.

- Another focus area for training was situational training and role playing to help prepare for dealing with Wounded Warriors' medical issues, specifically PTSD and TBI. They also acknowledged that initial training was geared to combat wounded. However, since they have a high percentage of non-combat wounded medical issues, such as how to deal with cancer patients, motorcycle accidents, and other injuries, it would also be beneficial to better understand how to facilitate their recoveries.

Platoon leaders interviewed did not indicate they had received any specific training to help them in their positions as platoon leaders, other than military leadership classes such as the Sergeants' course. However, they identified their desire to have a formalized training program that would include the following topics, among others:

- Wounded Warrior Transition Process
- Medical Evaluation Board Process
- PTSD and TBI and how to deal with Wounded Warriors with these conditions
- Suicide Awareness and Prevention Training

One platoon leader who had previously been deployed said he had attended "Back on Track," a program to help with his own post-traumatic stress. This 2-week program was designed for Marines who may be experiencing deployment-related Post Traumatic Stress symptoms (depression, anxiety, and disassociation). The program used group therapy to cover topics such as post-traumatic stress education, anger management, sleep hygiene, nutrition, physical fitness, stress management, spirituality, grief and loss, problem solving, and family relationships. This platoon leader believed that the course had helped him to deal more effectively with the challenges of managing Wounded Warriors.

In general, RCCs interviewed indicated that all recovery team members could benefit by having more training on PTSD and TBI. In addition, all unit leaders needed "compassion training" to develop an awareness and understanding that Wounded Warrior medical conditions could result in unusual behavior than that otherwise expected from a Marine in a regular unit, especially for those Marines with PTSD or TBI issues. The RCCs said that leader sensitivity training could assist platoon leaders when dealing with anger issues, and also to help them understand differences in requirements for those Marines who are transitioning versus those intending to remain on Active Duty.

Additionally, the RCCs identified the need for additional training on the MEB/PEB process, noting that Marines spend about 90 percent of their time maneuvering through the system, and understanding the process would enable them to better assist their Wounded Warriors.

Furthermore, several RCCs expressed concern that the staff did not understand the RCC role, and that often they were not treated with professional courtesy by regiment and battalion staff. They believed that training on RCC roles and responsibilities could help these staff work with RCCs more effectively.

C.2. Conclusion

Incorporating a comprehensive initial training and orientation program, as well as ongoing education and training opportunities would ensure that Recovery Team members were prepared to handle the challenges of supporting the care and recovery of Wounded Warriors. Recovery Team members conveyed their belief that they needed additional training opportunities for detecting, managing, and coordinating the complex issues associated with Warrior transition. By having these additional skills the Recovery Team members believed they would be better prepared to assist the Warriors and their families.

C.2. Recommendation, Management Comments, and Our Response

C.2. We recommend that the Commander, Wounded Warrior Battalion-East develop a comprehensive training and orientation program, to include roles and responsibilities of recovery team members, and ongoing educational training opportunities to ensure that recovery team members are prepared to deal with the challenges of helping Wounded Warriors heal, recover and transition either back to active duty or return to civilian life.

Wounded Warrior Battalion-East Comments

The Commanding Officer, Wounded Warrior Battalion-East concurred with comment to our recommendation. The Commanding Officer explained that over the past 18 months, they have created and implemented a robust training program for all military and civilian staff. Mandatory training includes, but is not limited to, medication safety, teamwork, leadership, conflict resolution, substance abuse rehabilitation; elective courses offered by the Wounded Warrior Battalion-East Licensed Clinical Consultant on Compassion Fatigue, Survivor's Guilt, Stress Management, Behavioral Health Emergencies, PTSD, and TBI. Other training opportunities included stress management classes to address caregiver burnout. He further explained that the Wounded Warrior Regiment recently implemented computer-based training courses which were required for military and civilian staff members. Computer-based training ranged from Compensation and Benefits, Special Compensation for Assistance with Activities of Daily Living, Integrated Disability Evaluation System, Group Life Insurance, Veterans Support Organizations, to Identifying Signs and Symptoms of Suicide, and Intervening in Suicidal Crisis. Additionally, special staff members were able to attend training specific to their respective positions.

Our Response

The Commanding Officer's comments are responsive and the actions meet the intent of the recommendation. No further action is required.

C.3. Abuse of Illegal Drugs and Prescribed Medications

Incidence of both prescription and illegal drug abuse, which were viewed as problematic by leadership, were identified within the WWBn – East. As a result, inadequate order and discipline and risks to physical health and safety may have negatively impacted the Warriors’ recovery and prolonged their transition time.

C.3. Background

The WWBn-East Battalion Order 6000.1, “Procedures for Medication Inventory Control and Assignment to the Prescription Risk Program,” October 19, 2009 states that “the majority of Marines who were attached to WWBn-East were required to maintain significant amounts of both controlled substances and over-the-counter medications for the treatment of their medical conditions. Once the prescription medications were received, it was the Marine’s responsibility to maintain proper accountability and to take medications as directed.”

Additionally, the Battalion Order outlines policies and procedures to follow to assist the Battalion staff in “supervising proper medication accountability and dosage taking of each individual Marine.”

WWBn-East Battalion Commander’s intent was as follows: “The purpose of the medication inventory control program was to ensure that all Marines and Sailors are maintaining proper medication accountability and dosages per their prescription instructions. As the Marines and Sailors of Wounded Warrior Battalion-East make their transition back to the fleet or civilian life, they must continue to be self-sufficient and responsible for their own medication. The intent of this program was to create a structured individual medication inventory process that provided a tool for more effective supervision and accountability of medication use. The end state was a patient population that was correctly medicated and educated on maintaining their own personal medication accountability.”²⁶

C.3. Discussion

During our briefings and interviews we were made aware that drug abuse in the barracks was a problem. Specifically, Battalion leaders were concerned about the misuse and/or abuse of prescription medications that were in the possession of Wounded Warriors. Additionally, they were concerned with the prevalence of illegal drugs which were available in the civilian towns surrounding Camp Lejeune, and that Wounded Warriors were vulnerable to exploitation by local illegal drug traffickers.

The Battalion Commander said he made “combating drug abuse his number one priority.” He did not believe that all Wounded Warriors were abusing drugs. On the contrary, he thought that out of 400 Marines in the Battalion, only 10 had drug abuse issues. However, the Commander said that this compromised population was vulnerable to exploitation if left unguarded. Additionally, he asserted that he had an obligation to “protect Marines from drug dealers.” He

²⁶ Wounded Warrior Battalion-East Battalion Order 6000.1, “Procedures for Medication Inventory Control and Assignment to the Prescription Risk Program,” October 19, 2009.

had initiated a “very aggressive urinalysis program as well as worked with the Battalion Surgeon, to assist Marines in dealing with pain management issues to prevent prescription or illegal drug abuse and addiction.”

Battalion staff and medical support staff acknowledged that efforts were needed to help control the potential for Wounded Warriors to misuse their prescription medications and/or illegal drugs. Specifically:

- A senior Marine official stated that they have had problems with illegal drug use in the barracks and had put in place random drug testing. This official noted that they were working with local authorities on five cocaine cases, among others. Any positive drug tests that indicated illegal use of drugs were usually handled through the Uniform Code of Military Justice process, including Non-Judicial Punishment.²⁷ Additionally, he mentioned that they had requested Electronic Medication Management System (EMMA)²⁸ units (also see D.4) to help control the quantities of prescribed medications that are available to a Marine at any one time. However, as of the time of our visit, the Battalion was having difficulty getting the required approval to use this system.
- A senior Battalion support staff member commented that the battalion had shifted to conducting more aggressive drug screening to identify those Warriors who had abused prescription and/or illegal drugs. He believed this had led to the apprehension of a specific drug dealer in town. Those Warriors caught abusing drugs were now provided counseling and treatment, where in the past this may not have been the case. Warriors were still held accountable and received disciplinary action by battalion leadership, but he believed these changes had helped ensure that “this vulnerable population was not taken advantage of by drug dealers” in the community.

Other challenges related to potential medication and drug-related issues identified during our interviews were for example:

- During the barracks tour, a senior Marine official acknowledged that some Marines were addicted to their pain medications, and others had “abused illicit drugs.” He further explained that the “command understood and often was lenient on first time offenders who abuse prescription drugs.” However, some Warriors used their injuries or conditions as a “shield” to justify recreational drug use and attempted to exploit USMC sensitivity to Warriors in order to use and sell illicit drugs (e.g. marijuana, cocaine, heroin, and crystal methamphetamine).

²⁷ The Uniform Code of Military Justice is the statutory code of military criminal law applicable to all U.S. military members worldwide. Non-Judicial Punishment is known by different terms among the services, such as “Article 15,” “Office Hours,” or “Captain’s Mast,” but the purpose of NJP is to discipline servicemembers for minor offenses such as, reporting late for duty, petty theft, and sleeping on watch.

²⁸ The EMMA system is a computerized medication dispenser for either inpatient or outpatient use. The system is programmed by the patient’s healthcare provider and can dispense individual doses of 10 different drugs for up to a month’s supply. Prescriptions and refills are prepared in blister cards dispensed by a pharmacy to the patient; the cards are then loaded into the dispenser.

- Several battalion leaders expressed that there was no real check between civilian and military medical providers of medications. As a result, Marines could and did duplicate prescriptions in excessively large quantities because the two systems were not reconciled. However, they explained that the battalion had implemented medication reconciliation²⁹ in order to get control over the quantities of medications provided for Marines.
- Regarding disciplinary actions, the leaders acknowledged that they try to begin with informal resolution for infractions then gradually increased the severity/formality of the consequences.
- During our interview with platoon leaders, one leader expressed concern that the Command allowed Combat Wounded/Purple Heart recipients to “get away with anything just short of murder”... although he also stated the command was supportive and listened to his recommendations. Another platoon leader noted that the level of support they get depends on circumstances of the event. He explained that this can set a “bad tone” by letting Marines see what other Marines were getting away with. He noted that there was significant flexibility and latitude in the disciplinary response to WWBn Marines engaged in street drug abuse, while the fleet policy is zero tolerance. He indicated however, that the system may need to treat abuse of prescription drugs in those Warriors with PTSD and/or TBI differently than others.
- During our interview with a senior medical official, he expressed concern about drug abuse and commented that the perception from “Washington D.C.” is that combat wounded Marines should be given a break. He indicated that “zero tolerance should be zero tolerance,” and that giving the Marines a break only put their families and others at risk.
- The Transition Center staff mentioned that the battalion tried very hard to look at the “Whole” Marine when deciding how to handle disciplinary issues, stating there were no easy answers. They added that the length of time it took to complete the medical board process affected the smooth and timely transitions, indicating that as a result the Warriors had too much time on their hands and tended to get into trouble.

Interviewed Warriors commented that the commander had emphasized concern about drug use and the selling of drugs during Warrior formations. They also indicated that they have a lot of drug tests, and explained that if a Warrior tested positive they were sent to a drug rehabilitation program and then they would be watched.

Managing medication misuse and drug abuse in this Wounded Warrior population presented sensitive and challenging issues. Many of our interviews supported the conclusion that the Command was trying to use the right approach to balance the appropriate amount of compassion

²⁹ Medication reconciliation is a formal process of identifying the most complete and accurate list of medications a patient is taking and using that list to provide correct medications for the patient anywhere within the healthcare system.

and empathy for a Warrior's situation with maintaining good military order and discipline when it came to involvement with inappropriate use of medications and/or illegal drugs.

We observed that the battalion had implemented measures to further mitigate prescription medication and illegal drug misuse such as installing video cameras in the barracks to deter thefts.

Furthermore, the Battalion Commander attempted to educate and motivate Wounded Warriors to act appropriately. Specifically, he told Marines, "Do not let your injury justify your misconduct." He clarified that "if you compromise your integrity by engaging in misconduct or illegal activity, then society will care less about you and you in turn will promulgate a negative attitude toward the Marine Corps and military service."

C.3. Conclusion

Many WWBn-East Wounded Warriors were required to maintain significant amounts of both controlled substances and over-the-counter medications for the treatment of their medical conditions. Additionally, this population was vulnerable to the illegal drug trade that was present in the civilian community. Consequently, the WWBN-East was required to implement measures to help mitigate the potential for misuse of prescription medications and/or the use of illegal drugs.

Although the Battalion had implemented appropriate actions, challenges to the command remained in dealing effectively with the abuse of prescribed medications and illegal drugs. As a result, Warrior recovery and transitions may be adversely affected.

C.3. Recommendations, Management Comments, and Our Response

C.3. We recommend that the Commander, Wounded Warrior Battalion-East:

C.3.1. Work in conjunction with Naval Hospital Camp Lejeune to implement measures which can decrease the potential for Wounded Warriors to misuse and/or abuse prescription medications, including the following:

C.3.1.a. Determine the appropriateness of and implement the Electronic Medication Management System for designated "high-risk" and other potentially vulnerable Warriors;

C.3.1.b. Improve medication reconciliation procedures to ensure medications prescribed by civilian providers in the community are reconciled with those prescribed at the Naval Hospital to ensure that quantities of medications available to Wounded Warriors are appropriate and not contraindicated; and,

C.3.1.c. Establish procedures for the disposal of prescription medications that are no longer needed by the Wounded Warrior.

Wounded Warrior Battalion-East Comments

The Commanding Officer, Wounded Warrior Battalion-East concurred with comment to our recommendations. The Commanding Officer explained that he along with selective staff members were briefed on the Electronic Medication Management Assistant (EMMA) in early 2010 and were convinced of its application for “high-risk” and vulnerable wounded warriors. He further explained that EMMA has not been approved by the Navy Bureau of Medicine and Surgery (BUMED), therefore, has not been implemented. The Commanding Officer, in response to medication reconciliation procedures, mentioned that a new Battalion Order 6000.1B, “Procedures for Facilitation of the Wounded Warrior Battalion-East Prescription Reconciliation Program,” was signed October 2011. The directive focuses on medication inventory, pain management, and identification of and assistance to high-risk patients. He further explained that the Battalion Order states that “no WWBn-East patients who are prescribed narcotics or sedatives will be permitted to go to a pain management provider or clinic in the civilian community unless authorized by the unit or detachment primary care manager.” Additionally, the order states that if narcotics are procured outside the network, Marines are in violation and subject to administrative or disciplinary action. Lastly, the Commanding Officer explained that under current Federal law, only patients can dispose of their own medications, and that the only legal and proper way was for the patient to give their medications to a Federal law enforcement officer. On Camp Lejeune, those working under the Provost Marshal are considered Federal law enforcement officers. Since the visit by the DoD IG, the battalion in coordination with the Base Provost Marshal conducted a separate turn-in of prescription medicine in November 2011 at the WWBn-East barracks with minimal results.

Additionally, the Commanding Officer, Wounded Warrior Battalion-East recommended that we update information in the report that had been listed incorrectly and/or changed since our visit. Specifically, updates to Wounded Warrior Battalion East sites (page 4); 9-Block Representatives, (Table 3, page 16, and Appendix A, (page 87). The recommended changes are also reflected in Appendix D.

Our Comments

The Commanding Officer’s comments are responsive and the actions meet the intent of the recommendations. The recommended changes as noted above have been updated in the report. No further action is required.

Observation D. Challenges for Naval Hospital Camp Lejeune

We observed four challenges related to Warrior medical care provided by Naval Hospital Camp Lejeune. The Naval Hospital should address these challenges in order to ensure more effective support for the care, healing, and transition of Wounded, Ill and Injured Marines. They are as follows:

- D.1.** Access to Specialty Healthcare Services
- D.2.** Lengthy Transition Times
- D.3.** Medical Case Management Staffing
- D.4.** Medication Management for Warriors

We believe that addressing these challenges will increase the effectiveness of the Naval Hospital's leadership and staff in providing quality and timely care and services in support of the recovering Marines to promote their healing and transition.

D.1. Warriors' Timely Access to Specialty Medical Care

Warriors had difficulty obtaining timely appointments for some specialty care services; specifically, Neurology, Orthopedics and Pain Management. As a result, necessary medical evaluations and treatments may have been delayed and could adversely affect a Warrior's recovery and necessary medical evaluations and transition.

D.1. Background

Camp Lejeune is located on the Eastern Coast near Jacksonville, NC. The base and surrounding community is home to an active duty, dependent, retiree and civilian employee population of approximately 180,000. The nearest large city (Raleigh, NC) is approximately 100 miles away and has a population of approximately 276,093.

Fayetteville Veterans Administration (VA) Outpatient Clinic, located in Jacksonville provided primary care and behavioral health services and is approximately 8 miles from Naval Hospital Camp Lejeune. Additionally, the Fayetteville VA Medical Center is located about 2.5 hours (109 miles) from Naval Hospital Camp Lejeune.

The patient services provided by Naval Hospital Camp Lejeune consisted of:

- Primary Care: Family Medicine, Pediatrics, Internal Medicine, and Branch Clinics
- Specialty Care: Mental Health, Emergency Medicine, Optometry, Obstetrics/Gynecology, Dermatology, Orthopedics, Anesthesia/Pain Management, Physical Therapy, Occupational Health, and Neuropsychology
- Clinical Support Services: Radiology, Laboratory, Pharmacy, Nutrition Management, Preventive Medicine, Deployment Health Center, and Substance Abuse Program

Figure 4 shows the Regional Referral Centers utilized by Camp Lejeune and their distances from the base ranging anywhere from 5 to 195 miles.

Figure 4. Naval Hospital Camp Lejeune Regional Referral Centers



The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) Policy Memorandum 06-007, “TRICARE³⁰ Policy for Access to Care and Prime Service Area Standards,” February 21, 2006, includes referral standards for Specialty Care Services, which stated that “Beneficiaries must have an appointment with an appropriately trained provider within four weeks and within one hour’s travel time from the beneficiary’s residence.”

Furthermore, the ASD (HA) Policy 06-007 was rescinded and replaced by ASD (HA) Policy Memorandum 11-005, “TRICARE Policy for Access to Care,” February 23, 2011. The policy includes referrals for Specialty Care Services, stating that beneficiaries must be offered an appointment with an appropriately trained provider within 4 weeks (28 calendar days) or sooner, if required, and within 1-hour travel time from the beneficiary’s residence.

D.1. Discussion

Warriors indicated that, for the most part, they were satisfied with the support provided by their Primary Care Manager (PCM). However, Warriors reported in multiple interviews that they had challenges receiving specialty care. They believed that they did not receive timely access to certain types of specialty medical care, such as neurology, orthopedics and pain management.

During an interview with the Naval Hospital Camp Lejeune hospital directors, they reported that 94 percent of civilian providers in Camp Lejeune’s catchment area³¹ were enrolled in the network.³² However, several areas of concern were ENT, Dermatology, Neurology, and Neuropsychological testing. The directors explained that when the case loads were too high, the Military Treatment Facility (MTF) would schedule appointments directly with non-network providers to help meet TRICARE access standards. Table 4 depicts the list of the top ten specialty network referrals for August 2010 and the average for 2010 as a comparison.

³⁰ TRICARE is the healthcare program serving Uniformed Service members, retirees, and their families worldwide.

³¹ Catchment areas are geographic areas determined by the Assistant Secretary of Defense (Health Affairs) that are defined by a set of five digit zip codes, usually within an approximate 40 mile radius of military inpatient treatment facilities.

³² The network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime TRICARE contractor as part of the total contracted delivery system. The agreements for health care delivery made by the contractor with the MTFs are also included in this definition.

Table 4. Top Ten Service Network Referrals

Category	August 2010	2010 Average
Optometry	297	148
Behavioral Health	290	257
Orthopedics	161	146
Neurology	89	122
Sleep Study	115	122
Pain Management	106	79
Neurology	89	122
Dermatology	74	58
Podiatry	64	75
Gastroenterology	57	45

The Commander noted that behavioral health referrals were 290 in August 2010, higher than the 2010 monthly average of 257. Orthopedics network referrals were higher in August 2010 at 161, greater than the monthly average of 146. Furthermore, pain management referrals were also higher, reaching 106 in August 2010 compared with the monthly average of 79.

The hospital Commander explained that there were additional challenges that contributed to access to care issues. The first was space limitations, but the Commander noted that over the next four to five years there would be ongoing activity to expand and renovate. Specifically,

- A new ambulatory care wing (including Family Practice, Orthopedics, physical therapy, and occupational therapy among others), plus a new Emergency and Acute Care wing, were projected for completion by winter 2013. The Commander said that even with the expansion, it was estimated that they would still fall 40-50,000 square feet short because of projected growth in behavioral health needs for the Marines stationed at Camp Lejeune.
- Another challenge cited by hospital directors was that, based on the geographic location of the MTF, staffing shortages were a concern. It was difficult finding medical providers in the area with the right skill sets. Moreover, military medical providers' periodic deployments contributed to the personnel shortages. One director mentioned that they had worked to increase the number of military billets; in addition they had optimized the use of other services such as the Public Health Service, the Defense and Veterans Brain Injury Center (DVBIC),³³ and supplemented staff with military providers from Portsmouth on a temporary duty assignment or detail.

³³ The Defense and Veterans Brain Injury Center (DVBIC) is a multi-site medical care, clinical research and education center funded by the Department of Defense (DoD). It conducts and advances research that enhances the quality, appropriateness, timeliness, and cost-effectiveness of treatment delivered to military and veteran beneficiaries with traumatic brain injuries (TBI) across the continuum of care.

A physician on the hospital staff indicated that providing specialty care could be difficult due to coordination of care issues and that care in the network could be challenging because of distance, and limited availability of specialists. He also stated that Camp Lejeune was a “medically underserved area” due to its geographic location, making it difficult to attract quality medical care providers. He went on to explain that exposure or cognitive behavioral therapy³⁴ referrals (those used in treatment and therapy of PTSD) could be especially difficult to obtain. Other challenges related to the medical appointment system identified by staff, Warriors and family members during our interviews were, for example:

- The Medical Case Managers (MCMs) stated that some clinics at the Naval Hospital Camp Lejeune managed their own appointments, while others depended on the central appointment system. The MCMs also said that in-house neurology and orthopedics clinics had limited appointments, and noted that these clinics did not have enough follow-up appointments. Furthermore, PTSD group therapy was backed up for 4-months, due to Warriors preference to be seen by military health care providers instead of non-military providers.
- Several family members explained that access to care for their spouses was “terrible” in their judgment. For example, most of the Naval Hospital Camp Lejeune clinics only opened schedules three weeks in advance and when called for an appointment they were often already booked. One family member commented that it took approximately 3 months to get a neurology appointment for her spouse, and 2 months for a pain management appointment.
- Another family member voiced concerned that her husband, who had received inpatient treatment for a mental health condition, did not receive an outpatient follow-up appointment with mental health for a month. She was concerned that all of the progress he made as an inpatient would be lost. She further explained that her husband had recently had an acute mental health issue and was then seen right away. However, her concern was more with the lack of accessibility for follow-up outpatient appointments. Several spouses stated that the behavioral health clinic on base was too busy, as were the services in town, and many in town would not or could not provide family therapy.
- Several Warriors indicated that neurology appointments could take up to four months. One Warrior stated that it took 3 ½ months to receive a VA mental health appointment.

³⁴ Exposure therapy: Over time, people with PTSD may develop fears of reminders of their traumatic event; the goal of exposure therapy is to help reduce the level of fear and anxiety connected with these reminders, thereby reducing avoidance. Cognitive behavioral therapy is a relatively short-term form of psychotherapy that focuses on present thinking, behavior, and communication, rather than on past experiences, and is oriented toward problem solving. Cognitive therapy has been applied to a broad range of problems including depression, anxiety, panic, fear, eating disorders, substance abuse, and personality problems.

D.1. Conclusion

Access to certain specialty medical care was a challenge due to the location of Camp Lejeune and lack of sufficient specialists to meet patient demand in compliance with established DoD TRICARE access to care standards. The ramifications of not receiving timely care are that Warriors at Camp Lejeune and their families were not receiving essential specialty medical care on a timely basis, which could impede healing and recovery, and hinder transition to civilian life. For amplifying remarks by Warriors concerning this section, refer to Part III, Warriors Speak.

D.1. Recommendations, Management Comments, and Our Response

D.1.1. We recommend that the Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery:

D.1.1.a. Establish policies and procedures to uniquely identify Wounded Warriors assigned or attached to a Wounded Warrior Battalion in the Composite Health Care System, so that established DoD TRICARE access to care standards specifically for the Wounded Warrior population can be tracked.

Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery Comments

Bureau of Medicine and Surgery concurred with comments to our recommendation. In July 2011, Bureau of Medicine and Surgery, Wounded, Ill, and Injured Program Support sponsored a multi-regional, multi-disciplinary working group to examine programs/systems currently used to collect/monitor deployment or wounded, ill and injured data/information. The working group identified a likely platform that would provide the architecture for a usable Wounded, Ill, and Injured registry for the regions, and the ultimate linkage to the Composite Health Care System (CHCS). Currently, one of the clinical regions is incorporating assigning Wounded Warriors with Health Care Delivery Code 0415 to the Defense Enrollment Eligibility Reporting system (DEERS)/CHCS, while an enterprise-wide solution is pending further review of all options.

Our Response

Bureau of Medicine and Surgery comments are partially responsive. Based on the response, it is not clear whether other clinical regions are assigning Wounded Warriors to the same Health Care Delivery Code and there is no stated timeline in which an enterprise-wide solution will be approved for implementation. In response to the final report, we request that the Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery provide additional comments on this recommendation, specifically, by providing an estimated timeline for approval and implementation, and stating what measures have been put into place to ensure warriors in all clinical regions are accurately coded.

D.1.1.b. Establish policies and procedures to ensure Wounded Warriors assigned or attached to a Wounded Warrior Battalion receive every medical appointment within established DoD TRICARE access to care standards.

Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery Comments

Bureau of Medicine and Surgery concurred with comment to our recommendation. Bureau of Medicine and Surgery (BUMED) explained that Wounded Warriors assigned to the Wounded Warrior Battalion typically are afforded the services of clinical case management at the Military Treatment Facility and/or embedded within the battalion. They further explained that warriors are also enrolled/assigned a primary care provider for managing all health concerns within the Medical Home Port. Additionally, BUMED stated that they will provide resolution of any clinical concerns addressed and would assist in alleviating any access to care challenges based on the Naval Hospital Camp Lejeune manpower study results, which as noted will be completed no later than April 2012 (*see recommendation D.1.2*). Furthermore, regarding guidance on existing policies and procedures BUMED will continue to discuss and ensure current and emerging gaps and challenges are addressed.

Our Response

Bureau of Medicine and Surgery comments are partially responsive. Bureau of Medicine and Surgery stated that they will work with Naval Hospital Camp Lejeune to take appropriate actions to provide adequate staffing for all specialty medical care activities based on the results and recommendations derived from the manpower study, which is projected to be completed no later than April 2012 (*see recommendation D.1.2*). Upon receipt of the manpower study, we request that the Bureau of Medicine and Surgery provide comments stating the actions that will be taken based on the manpower study results.

D.1.1.c. Based on results of the Naval Hospital Camp Lejeune manpower study and the Commander's recommendations (*see below*), take appropriate actions to provide adequate staffing for all specialty medical care activities assigned to Camp Lejeune.

Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery Comments

Bureau of Medicine and Surgery concurred with comment to our recommendation. Bureau of Medicine and Surgery explained that upon completion of the Naval Hospital Camp Lejeune manpower study, they will assess the validated results for any follow on staffing actions.

Our Response

Bureau of Medicine and Surgery comments are responsive and the actions meet the intent of the recommendation. No further action is required.

D.1.2. We recommend that the Commander, Naval Hospital Camp Lejeune, direct a manpower study to assess the need and feasibility to add specialty medical providers to the medical facilities assigned to Naval Hospital Camp Lejeune. Provide study results and recommendations to the Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery for action (see D.1.1.c.).

Naval Hospital Camp Lejeune Comments

The Commanding Officer, Naval Hospital Camp Lejeune concurred with comments to our recommendation. The Commanding Officer explained that Navy Medicine East has initiated a manpower study regarding Wounded Warrior Specialty care and plans to conclude the study no later than April 2012.

Our Response

The Commanding Officer's comments are responsive and the actions meet the intent of the recommendation. No further action is required.

D.2. Lengthy Transition Times

Warriors' healing and transition was comprised of treatment, rehabilitation, recovery, the medical board process, and transition back to Active duty or to civilian status. WWBn-East Warriors spent an average of 245 days in the treatment, recovery and rehabilitation stages. As a result, the prolonged transition period had potential negative effects on some Warriors' healing and transition.

D.2. Background

The Disability Evaluation System (DES) is the mechanism by which a Service member is evaluated for fitness for duty by DoD. The legacy DES is a DoD process that assesses Service member's fitness for duty and compensates for injury or disease incurred in the line of duty that inhibits a Service member's ability to perform the duties of his/her office, grade, rank, or rating. DES includes a medical evaluation board (MEB); physical evaluation board (PEB),³⁵ and disability determinations; appellate review process, and final disposition.

In November 2007, DoD and VA initiated a joint DES Pilot program to improve the timeliness, effectiveness and transparency of the DES review process. A desired outcome was to close the gap that often occurred between separation from active duty and receipt of VA benefits and compensation. The program is now called the Integrated Disability Evaluation System (IDES). As of December 2010, the IDES had been deployed at 27 military treatment facilities – with worldwide deployment scheduled for completion in September 2011. Specifically, the IDES:

- Established goals for delivering VA benefits to active duty servicemembers within 295 days and to reserve component servicemembers within 305 days.
- Merged DoD and VA separate exam processes into a single exam process conducted to VA standards
- Consolidated DoD and VA separate rating phases into one VA rating phase. If the PEB has determined that a servicemember was unfit for duty, a rating specialist prepares two ratings – one for the conditions that DoD determined caused the servicemember to be unfit for duty, which DoD used to provide military disability benefits; and the other for all service-connected disabilities, which VA used to determine VA disability benefits.
- Provided VA case managers to perform outreach and nonclinical case management and explain VA results and processes to servicemembers.

Additionally, in January 2008, the National Defense Authorization Act for Fiscal Year 2008 (NDAA 2008) required DoD and VA, to the extent feasible, to jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering servicemembers, including improvement to the respective agencies' disability evaluation system.

³⁵ Physical Evaluation Board (PEB) is initiated after a MEB determines that the member has a medical condition which is incompatible with continued military service. The PEB is a formal fitness-for-duty and disability determination that may recommend one of the following: Return the member to duty, place the member on the temporary disabled/retired list (TDRL), separate the member from active duty, or medically retire the member.

The military’s legacy disability evaluation process begins when a physician identifies a condition that may interfere with a service member’s ability to perform his or her duties. Following an injury or illness, the Marine is given an appropriate period of time (typically 12 months) to receive treatment and hopefully to rehabilitate and recover.

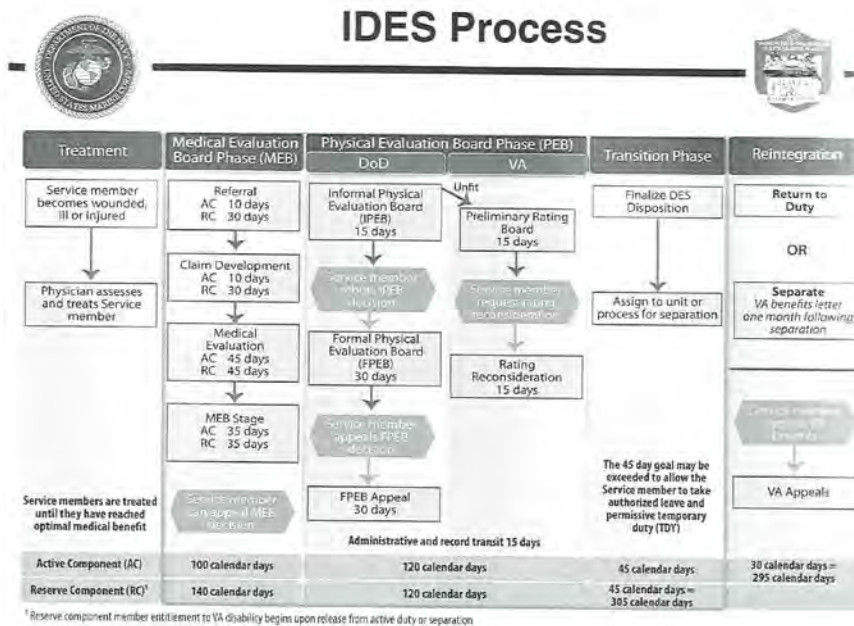
If a Marine cannot be returned to a full duty status and his or her ability to continue on active duty, even in a medically unrestricted status, remains in question, it is the responsibility of the medical community to refer the Marine to a MEB. On the basis of medical examinations and the servicemember’s medical records, an MEB identifies and documents any condition that may limit a servicemember’s ability to serve in the military. A Marine’s case is then evaluated by a PEB to make a determination of fitness or unfitness for duty. If the Marine is found to be unfit due to medical conditions incurred in the line of duty, the PEB assigns a combined percentage rating for those unfit conditions, and the servicemember is discharged.

To assist the Wounded Warrior through the DES process they are assigned a Physical Evaluation Board Liaison Officer (PEBLO) and a VA Military Service Coordinator (MSC) who as nonclinical case management specialists are responsible for providing information and assistance to the Marine and family during the DES process.

D.2. Discussion

Since March 31, 2009, when the IDES program was implemented at Camp Lejeune, the MEB processing had been a challenge. Figure 5, Integrated Disability Evaluation System, indicates the various stages of treatment to reintegration.

Figure 5. Integrated Disability Evaluation System Process



According to the Wounded Warrior Regiment (WWR), the average number of days a Warrior spent from the time they entered the WWBn-East until they transitioned out of the Marine Corps

was approximately 730 days (24 months). Furthermore, the average number of days the MEB process took for a Warrior in WWBn-East was approximately 245 days. Additionally, a data review from September 2010 indicated that for 22 percent of the WWR Marines, more than 3 years had passed since their original injuries with no referral to the IDES or return to active duty.

The hospital directors commented that they were working to implement mitigation strategies to streamline the process, but nonetheless, the process remained frustrating for both hospital staff and Marines because of the length of time.

A senior Marine official referred to the complicated DES process as “building an airplane in flight” and implored assistance for PEB processing from Washington Navy Yard in order to reduce time.

The hospital directors noted that the local VA was supportive and effective. However, the biggest “hold up” appeared to be with the PEB process conducted at the Washington Navy Yard. There was noted frustration in having to copy and submit FEDEX “stacks” of paperwork to the PEB board. One hospital director commented that the medical board process was very “administrative” burdensome. He also noted that in the past year the MTF had used over 1.5 million sheets of paper processing paper work for medical boards. The current PEB backlog was the immediate problem and the MTF was collaborating with the VA to make the process work.

According to the director, the Bureau of Medicine and Surgery medical board staffing model depicted a ratio for Marines to MEB counselors as 20:1, while Camp Lejeune consistently runs a ratio of 95:1 (including patients who are not part of the Wounded Warrior program). Based on the staffing model, the MTF had a requirement for 22 intake counselors. Currently, the MTF had only five counselors (four actually worked in counseling, while one was devoted to administrative work, and three vacancies were waiting to be filled). However, due to space limitations the MTF could only grow to twelve counselors.

Furthermore, the director explained that in March 2009 the case load was approximately 1060. An average of five to ten new cases were opened each day. Counseling was 20 percent of the work with 80 percent focused on administrative tasks. For example, personnel were required to generate 2 copies of every document for both PEB and VA because PEBs do not accept electronic copies for the board and do not access AHLTA, the military health systems electronic medical record.

During interviews with several WWBn-East senior leaders, one commented that the “Bottleneck is in DC” and it seems to take 5 to 6 six months to get a response from the Navy Yard. Others noted that Board processing takes a long time and that Marines’ recovery starts to digress when they are waiting on the disposition of their boards. They also noted that Marines get into trouble because “idle time is not good for individuals such as infantry Marines who are used to being challenged daily.” WWBn-East leadership stated that they all want “Healing-Transition-Restoration” but what they see is “Healing-Frustration-Declines,” with young people who end up being “very sad.” Another battalion representative believed that Marines had “diagnosis creep,” and seemed to find more wrong the longer they were there.

Battalion leaders acknowledged that the battalion's number one issue was transition speed. They explained that the PEB process was too long and it was a contributor to recovery problems. According to the battalion DES attorney, there is "Zero Transparency" regarding the VA Process. He noted that you can't go to one place and find out the status or location of a package in the VA system, stating: "I can go to amazon.com and track an order for a book but no such process exist for DES packages."

In addition to the lengthy IDES process, other challenges voiced by Warriors, families, medical support staff and others included incomplete packages, inaccurate medical information, expired packages, physician dictation problems, lack of MEB counselors, and tracking of packages. Specifically:

- One Marine Corps leader stated that part of the problem was getting the Marine to "optimum health" (when maximum medical benefit is determined). For some Marines, this could be a prolonged period, also contributing further to their stay in the Battalion. As noted by one hospital official, the biggest difficulty was that "warriors are stuck, bored, and industrious and get into trouble."
- During a family interview, one family member shared that it took four months to get the dictation back from her husband's neurologist.
- There was an overall consensus by the MCMs that the board process was too long, making it hard to keep Marines out of trouble while their board was being processed. They cited that deadlines for medical board paperwork expired because of the lack of resources to help process cases. This occurred because medical boards were understaffed; there was a need for more MEB counselors, and there were not enough VA representatives to handle the Camp Lejeune case load. Additionally, narrative summaries were being sent back by the board because addendums were not attached or complete, and Compensation and Pension exams were taking 6 months. As a result, other exams and consults expired. Historically, MCM were not involved in the medical board process, however, recently we were told a nurse was placed in the MEB office to help facilitate and track reports.
- The PCM commented that the MEB/PEB and DES process takes so long to complete. He also commented that there is a perception by the Marines that VA care is "bad" so the Marine stays around longer to get medical issues taken care of so they don't have to depend on the VA.
- One platoon sergeant within the battalion commented that the medical board counselors were overwhelmed. There was no access or formal relationship between the platoon leaders and the medical board counselors and PEBLO for tracking his/her Marines' progress through the MEB. Further, the platoon sergeant indicated that the most common issue with medical boards was that dictations expired after 6 months. He cited one incident about a Marine whose medical board process had to start over three times solely because the dictations expired. Furthermore, the platoon sergeant stated that the "longer a Marine is at WWBn, the worse the Marine becomes both physically and mentally."

A director explained, his concern with the length of the medical board process was that the lack of proper staffing created the “death spiral.” As more Marines required more behavioral health care, the burden on the mental health professionals increased, while the time available to the mental health professional for the lengthy medical board dictation decreased. The overall effect of the prolonged medical board process was that Warriors were retained in the WWBn for excessive periods of time, which often caused reduced morale and presented further opportunities for the Warrior to develop complaints about a new medical or mental health problem. This caused the MEB/PEB process to start over and/or led to behavior that required disciplinary action by the command.

D.2. Conclusion

We acknowledge the ongoing work that is being conducted by DoD and VA and others to rectify the multitude of issues and concerns facing the IDES process. However, we found a pervasive perception among Warriors, supporting personnel and Command leaders that the prolonged IDES process may be contributing to disciplinary problems among the Warriors assigned or attached to the WWBn. The local backlog of MEBs and the Washington Navy Yard backlog of PEBs appeared to be a major impediment to the necessary expediting of IDES processing and a barrier to timely recovery and transitioning of Warriors. Furthermore, the already-limited clinical appointments, and the costly and time consuming administrative (paper, resources and manpower) processing to prepare, and submit packages placed a demand on already-limited manpower resources at all levels.

D.2. Recommendations, Management Comments, and Our Response

D.2. We recommend that the Secretary of the Navy, take action to ensure that each phase of the Integrated Disability Evaluation System process is accomplished within the established timelines for every Wounded Warrior assigned or attached to Wounded Warrior Battalions.

Management Comments Required

The Secretary of the Navy did not provide comments on a draft of this report; however, based on the response of the Wounded Warrior Regiment’s Commanding Officer as noted in D.2.1.a. - D.2.1.e, (*see below*), we acknowledge that the Wounded Warrior Regiment and Naval Hospital Camp Lejeune are doing their part to track and expedite Marines through the IDES. We request that the Secretary of the Navy provide a response, specifically, to what actions are being taken to ensure that the IDES process is accomplished within its established timelines.

D.2.1. We recommend that the Commander, Wounded Warrior Regiment, track each separate phase of the Integrated Disability Evaluation System process.

D.2.1.a. Report every Medical Evaluation Board over 100 calendar days for Active Duty Warriors and 140 calendar days for Reservist Warriors to Deputy Commandant, Manpower and Reserve Affairs for action.

D.2.1.b. Report every Physical Evaluation Board over 120 calendar days for Active Duty and Reservist Warriors to Deputy Commandant, Manpower and Reserve Affairs for action.

D.2.1.c. Report every Transition Phase over 45 calendar days for Active Duty and Reservist Warriors to Deputy Commandant, Manpower and Reserve Affairs for action.

D.2.1.d. Report every Reintegration Phase over 30 calendar days for Active Duty and Reservist Warriors to Deputy Commandant, Manpower and Reserve Affairs for action.

D.2.1.e. Implement the maximum appropriate use of “Home Awaiting Orders” and “Temporary Disabled Retired List” to minimize the amount of time Warriors spend in Wounded Warrior Battalions.

Wounded Warrior Regiment Comments

The Commanding Officer, Wounded Warrior Regiment concurred with comments to our recommendations. The Commanding Officer stated that the Wounded Warrior Regiment currently generates a weekly brief for the Deputy Commandant, Manpower and Reserve Affairs (M&RA) action that captures the status of Marines in the Medical Board Evaluation (MEB) and Physical Evaluation Board (PEB) phases. By-name rosters of Marine cases exceeding phase processing goals are provided biweekly to the Bureau of Medicine and Surgery (BUMED) and PEB. The Commander further explained that since the DOD IG visit, there have been ongoing efforts to improve Integrated Disability Evaluation System (IDES) performance. He noted that in addition to hosting regular BUMED teleconferences with IDES stakeholders, Deputy Commandant, M&RA has been providing Marine Corps leadership with detailed IDES information, which has resulted in their ability to work closer with the Regional Medical Commanders on specific issues impacting IDES performance. Furthermore, the Commanding Officer stated that the Naval Hospital Camp Lejeune has proved to be the most successful in making IDES work as intended.

Our Response

The Commanding Officer, Wounded Warrior Regiment’s comments are responsive, however, further comment is still requested by the Secretary of the Navy *as recommended in D.2.*

D.3. Medical Case Management Staffing

The MCMs from the Naval Hospital assigned to manage Warriors at WWBn-East operated at their maximum number assigned and sometimes exceeded their caseloads. Consequently, Warriors may not have always received the medical case management support they needed causing delays or other potential adverse affects to their recovery and transition.

D.3. Background

The Navy does not have a standard fixed ratio that it uses to determine the number of patients per assigned case manager supporting Wounded Warrior battalions. However, the Department of the Navy Bureau of Medicine Instruction 6300.17, "Navy Medicine Clinical Case Management," November 23, 2009, followed the 2006 DoD TRICARE Medical Management Guide recommendation that the case load range from 10 to 50 patients per case manager, depending on acuity. Additionally, the 2008 DoD TRICARE Medical Management Guide, Case Management *Version 3.0*, establishes that no more than 17 Wounded Warriors in an outpatient setting will be assigned to one Medical Care Case Manager. Acuity levels are described in the USD P & R Directive Type Memorandum 08-033, "Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the Military Health System," August 26, 2009. Specifically, the acuity is based on the number of interventions that a case manager may be required to perform and the frequency of follow-up with the patient. Possible interventions include activities such as medication counseling, arranging durable medical equipment, and communicating with and/or educating family members and others.

D.3. Discussion

The assignment of Marines to the appropriate MCMs was based on the acuity of the Marine and skill set of the MCM (as previously discussed in B.3., Assignment of Warriors to Medical Case Managers). Acuity levels were based on the amount of contact and interventions the Marine would have with the MCM, the acuity levels range from 1 to 5 with acuity level 5 requiring the most intervention and contact. Table 5 shows the number of MCMs to Wounded Warriors at Camp Lejeune.

Table 5. Medical Case Managers to Warrior Ratios

MCM	Warriors Assigned
A	20
B	50
C	44
D	46
E	15
F	40
G	28
H	27
I	42

During interviews with the MCMs, they explained that there were three Licensed Practical Nurses (LPN)³⁶ that work at the hospital and were available to assist with case management duties. However, they were often busy with their own, less complex case loads. Ideally, they stated, having one LPN assigned full time to WWBn-East would be helpful. They expressed the need for additional MCMs, because “there are many more combat wounded who were not being seen or getting the proper support they need.” Several MCMs stated that even though overworked, “we love our job,” “we put our heart and soul into it” and “we have a lot of support and respect from all over.” Others commented that the “job is all consuming,” “never-ending,” and “not a day goes by where I have enough time to do the job.”

We were informed during our family interviews that several individuals thought that their spouse’s case manager was difficult to reach or not responsive. Specifically, during two family interviews, one spouse mentioned she made all her husband’s appointments and another family member commented that they did not use the case manager any longer because they could never get in touch with her.

D.3. Conclusion

Although the MCMs were working within the parameters of the Navy guidance, they exceeded the caseload assignments as established by DoD for Warrior ratios. The MCMs expressed concern that they did not have enough time to complete their duties and that the Warriors with more complex health care requirements may not be getting the proper support they need for recovery and transition. This placed the MCMs at potential risk of not being able to effectively work each individual Warrior’s specific medical and/or transition needs. The overarching guidance for MCMs to Warrior ratios should be reviewed to identify minimal ratios based on care acuity, complexity and evidence-based practices.³⁷ Furthermore, the DoD policy for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the Military Health System was outdated and lacked follow-on guidance. For amplifying remarks by Warriors concerning this section, refer to Part III, Warriors Speak.

³⁶ Licensed practical nurses (LPNs) care for people who are sick, injured, convalescent, or disabled under the direction of physicians and registered nurses. The nature of the direction and supervision required varies by State and job setting.

³⁷ Evidence-based practice is the practice of health care in which the practitioner systematically finds, appraises, and uses the most current and valid research findings as the basis for clinical decisions.

D.3. Recommendation

We recommend that the Undersecretary of Defense for Personnel and Readiness, comply with the requirement to replace the existing Directive-Type Memorandum 08-033, Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the Military Health System, and develop a DoD Instruction establishing adequate Medical Case Managers staffing ratios specific to Wounded Warrior programs based on patient care acuity, complexity, and evidence-based practices.

Undersecretary of Defense for Personnel and Readiness Comments

The Undersecretary of Defense for Personnel and Readiness partially concurred with comment to our recommendation. The Undersecretary agreed to comply with the transition of the Directive-Type Memorandum 08-0333 into a DoD Instruction and concurred in working towards establishing case manager staffing ratios that will consider variables associated with acuity and complexity of care coordination requirements, and consistent with the statutory requirements of the National Defense Authorization Act for Fiscal Year 2008, Section 1611 (e) (3) (C), recognizing that the secretaries of the Military Departments concerned may waive such limitation with respect to a given manager for not more than 120 days in the event of unforeseen circumstances.

Our Comments

The Undersecretary of Defense for Personnel and Readiness's comments are partially responsive. We request that the Undersecretary provide an estimated timeline for the DoD Instruction implementation.

D.4. Medication Management for Warriors

The Naval Hospital Camp Lejeune did not have specific medication management policies or procedures in place to manage Warriors who were prescribed multiple medications, some of which were controlled substances. Consequently, Warriors were at risk to have an adverse reaction from these medications, which could negatively affect their health and recovery.

D.4. Background

Naval Hospital Camp Lejeune Instruction 6710.5A, “Controlled Medication Utilization Review and Intervention Protocol,” September 15, 2003, established a protocol for the continuous review of controlled substances³⁸ prescribed in the outpatient setting. Specifically, this guidance:

- Established a protocol for the continuous review of prescribing controlled substance and outpatient use. A step in the protocol requires the pharmacist to generate a report listing all patients who have received five or more controlled medications within a 2 month period.
- Described the purpose of the Controlled Medication Utilization Review and Intervention Subcommittee, which is responsible for monitoring patient medication usage, and to identify, report and intervene in medication misuse cases involving controlled medications (Schedules II-V).³⁹
- Tasked the Controlled Medication Utilization Review and Intervention Subcommittee to review prepared reports and identify patients, or providers, exhibiting “misuse” characteristics, and to follow up with appropriate medical care providers (e.g. PCM, Specialist, Case Manager, Social Work, or Substance Abuse Rehabilitation Program Coordinator) regarding any care and treatment concerns.

Additionally, Naval Hospital Camp Lejeune Instruction 6320.55B, “Pain Assessment and Management,” December 16, 2008, established policy and procedure for patients with acute and chronic pain. Specifically this instruction:

- Prescribed frequency and method of assessing patient pain, and identified appropriate interventions.
- Provided recommendations for considerations in using opioids.⁴⁰
- Described the policy and procedure, when initiating a regular opioid regimen, including an Informed Consent/Agreement Form for Long Term Controlled Substance Therapy.
- Provided recommendations regarding the use of opioids in the treatment of non-cancer pain, although this is not exclusive to the care of Wounded Warriors.

³⁸ A drug or chemical substance whose possession and use are controlled by law.

³⁹ A controlled substance is placed in its respective schedule based on whether it has a currently accepted medical use in treatment in the United States and its relative abuse potential and likelihood of causing dependence.

⁴⁰ According to the Merriam-Webster, Inc., Medical Dictionary, copyright 2010, an opioid possesses some properties characteristic of opiate narcotics but are not derived from opium.

Battalion Order 6000.1, "Procedures for Medication Inventory Control and Assignment to the Prescription Risk Program," October 19, 2009, described the policy and procedure to supervise the proper medication accountability and dosage taking of each individual Marine and Sailor attached to the Battalion. The goal of this program is to create a structured individual medication inventory process as a tool for more effective supervision and accountability of medication usage. Specifically, it:

- Required that monthly medication inventories be conducted on Marines/Sailors in a patient status at WWBn-East (pills counted and compared to prescription frequency)
- Described procedures to follow if the inventory had fewer than the minimum quantity as stated on the prescription label, in which case these Marines/Sailors would be assigned to the "prescription risk program," whereby two medication inventories per week would be conducted for 60 days, and
- Identified medications that were no longer used or needed and should be discarded

D.4. Discussion

We noted that both the battalion and hospital had established guidance to address the use of controlled medications (including opioids), the management of patients with pain, and medication accountability. However, we believed that these orders, policies and procedures were not sufficient and therefore effective to assist the medical and battalion staff in managing the challenges of caring for the specific patient population in the Wounded Warrior Battalion.

The pharmacist acknowledged during our interview that these hospital policies and procedures required a revision in order to address the challenges and complexities of providing care to Wounded Warriors. Additionally, the pharmacist stated:

- That the current policy/procedure required that the pharmacist produce a written report listing patients who were prescribed five or more controlled medications in a two month period. This report was intended to be reviewed by the hospital's Controlled Medication Utilization Review and Intervention Subcommittee to identify appropriate interventions if there was evidence of misuse of controlled medications.
- That preparing the report has now become unmanageable due to the large number of patients that have been prescribed five or more controlled medications.
- The system discrepancy between CHCS and AHLTA, whereby not all medications listed on the CHCS profile were successfully transcribed over into the AHLTA medication profile.

Additionally, Naval Hospital senior leadership and its medical staff directly involved in the health care and management of Wounded Warriors cited their own concerns with the challenges of managing the complex medication needs of Wounded Warriors. For example:

- One senior medical official during an interview stated that the “polypharmacy⁴¹ issue scares him to death” and acknowledged how difficult it was to deal with.
- A group of MCMs voiced their concern regarding medication management indicating that “the right hand does not know what the left hand is doing on base and the poly-pharmacy problem is amplified by the off-base providers.” One MCM expressed that the Pharmacy needed to get more involved, to include better tracking and alerts on medication interactions in AHLTA/CHCS.

Interviews with the Battalion’s senior leaders identified their concerns with the risks that were inherent in having Wounded Warriors who were taking or had access to multiple medications. Specifically:

- The Battalion Commander expressed concern that most if not all Marines in the battalion were on serious medications resulting from their wounds, illnesses and/or injuries. He believed that many Marines were “pre-disposed” to addictions and that although Navy Medicine was trying to “catch up” with these needs, there were still a number of Marines needing assistance with pain management and addiction counseling. The Commander further explained that he believed Wounded Warriors in the battalion were a “compromised population,” and that he made “combating drug abuse a number one priority.”
- Furthermore, Battalion senior leaders voiced concern that there was no real check on medications prescribed between civilian and military providers, so Marines could and had received duplicate prescriptions for large quantities of medications because the two systems were not reconciled. This led to the issuance of Battalion Order 6000.1A, “Procedures for Medication Inventory Control and Assignment to the Prescription Risk Program,” October 19, 2009. (This Battalion order was cancelled and has been superseded by Battalion Order 6000.1B, and is explained in recommendation *C.3.1.b*).
 - The policy was intended to help manage accountability of the number and types of medication that a Warrior may have in their possession. The Battalion believed that this process would help to get the quantities of medications for Marines under control.
- A battalion medical representative expressed concern that Warriors were being overmedicated, stating that many doctors were quick to prescribe medications as “an easy fix,” and then the battalion was left to deal with any resulting problems (e.g. overmedication, addiction). He also noted that some Warriors had their prescriptions filled in civilian network pharmacies instead of the Naval Hospital’s pharmacy.

Battalion leaders stated that additional measures were needed to help mitigate risks involved with Wounded Warriors possessing a large quantity of medications. Several efforts were identified that could assist or mitigate medication risks. For example:

⁴¹ Polypharmacy is the use of a number of different drugs, possibly prescribed by different doctors and filled in different pharmacies, by a patient who may have one or several health problems.

- Warriors' utilization of the EMMA system. The EMMA system allows for a single dose of medication to be dispensed at a specific time and could be used in a Warrior's room. A benefit of this system is that it limits the number of pills/capsules that are available to a Warrior at any one time. Although the advantage of using such a system was supported by both Battalion and hospital staff, the Battalion expressed their frustration that they had been unable to get approval from Navy Medicine to use EMMA. Even though Army units such as at Fort Bragg were using EMMA, the Battalion staff explained that Navy Medicine was concerned whether EMMA would be HIPAA compliant and allowable.
- Discarding of Warrior medications that were no longer needed or required for care due to a change in a Warrior's symptoms or condition. The disposal of these unused/un-needed medications was problematic due to concerns with polluting or adversely affecting the environment. Consequently, special procedures were required. In the past, the Naval Hospital coordinated an effort with the DEA to collect unused medications so that they could be properly destroyed and/or disposed of. However, these procedures were not conducted on a routine basis. A senior hospital official stated that they were working on developing a plan which complied with state laws to allow for a regularly scheduled collection of unused/un-needed medications.

D.4. Conclusion

Managing the medications for Wounded Warriors was challenging due to the number and types of medications that were prescribed, some of which are controlled substances, and the fact that both military and civilian health care providers were prescribing them. Battalion Orders and Hospital policies and procedures for handling multiple medications for Wounded Warriors were outdated, and lacked a process to specifically identify and track Warriors assigned to the battalion as a means to help mitigate the risk of adverse drug interactions or poor outcomes. Updated hospital policies and procedures could significantly assist in the identification and reduction of potentially harmful Warrior medication-related incidents. For amplifying remarks by Warriors concerning this section, refer to Part III, Warriors Speak.

D.4. Recommendations, Management Comments, and Our Response

D.4.1. Office of Assistant Secretary of Defense, Health Affairs, ensure that the Pharmacy Data Transaction Service/Armed Forces Health Longitudinal Technology Application interface adequately supports the medication reconciliation for prescriptions not ordered in the Composite Health Care System.

Assistant Secretary of Defense, Health Affairs Comments

TRICARE Management Activity (TMA) responding on behalf of the Assistant Secretary of Defense, Health Affairs concurred with comment to our recommendation. TMA explained that efforts are underway to enhance the medical reconciliation capability within AHLTA/Composite Health Care System (CHCS). TMA stated that currently, DoD healthcare providers are able to document changes to medication orders made by DoD providers but are unable to do so for medication orders from non-DoD providers, to include VA and civilian providers. TMA also commented that two system change requests (SCRs) have been approved to address this, which include:

- Allow users to mark as “Taking/Not Taking” each patient’s current medications regardless of the source system. For example, the source systems include but are not limited to AHLTA, CHCS, VA or Pharmacy Data Transaction Service (PDTS). This update can be done during a patient encounter or without initiating an encounter.
- Change the status of a medication to “Taking/Not Taking” when a user marks an over the counter (OTC) medication as “Taking/Not Taking.”

TMA stated that these enhancements are targeted for funding in Fiscal Year (FY) 2014. Additionally, TMA recommended changes be made to footnote 21 (page 30) regarding AHLTA. The recommended changes are also reflected in Appendix D.

Our Response

TRICARE Management Activity, responding on behalf of the Assistant Secretary of Defense, Health Affairs, provided comments that are responsive and meet the intent of the recommendation. However, we request that TMA provide updates when such enhancements have been approved and funded. The recommended changes as noted above have been updated in this report.

D.4.2. We recommend that the Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery:

D.4.2.a. Update command policies and procedures for overall medication management, to include polypharmacy management, medication reconciliations, and pain management practices including use of alternative therapies.

D.4.2.b. Coordinate with the Wounded Warrior Regiment to determine if the Electronic Medication Management System is an appropriate method to assist in the proper dispensing of medications to Warriors assigned or attached to Wounded Warrior Battalions.

Bureau of Medicine and Surgery Comments

Bureau of Medicine and Surgery Navy Pharmacy Consultant, responding on behalf of the Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery, concurred with comments to recommendation *D.4.2.a.* The Pharmacy Consultant explained that a review of directives and procedures for medication management may mitigate some of the issues identified in this report. However, the Consultant stated that licensed professionals are generally given latitude on selection of treatment options and how pharmaceuticals are prescribed, dispensed, and administered, based on professional judgment and specific patient presentation.

Bureau of Medicine and Surgery Navy Pharmacy Consultant, responding on behalf of the Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery, non-concurred with comment to recommendation *D.4.2.b.* The Pharmacy Consultant explained that the Electronic Medication Management System is a vendor-specific system. The Consultant further explained that the DoD IG report should not recommend a vendor-specific system, and noted that there are other electronic supported and non-electronic means to meet the identified requirement at the wounded warrior barracks. Additionally, the Consultant explained that evaluation of the most

appropriate method to control medication access/administration can be accomplished, to include patient population studies.

Our Response

Bureau of Medicine Navy Pharmacy Consultant comments to recommendation *D.4.2.a.* are partially responsive. Our recommendation does not address and is not related to the issue of a medical provider's latitude on selection of treatment options and the exercise of their clinical professional judgment. Rather, it relates to the current lack of overarching guidance for providing polypharmacy policies to support those professionals caring for Wounded Warriors and others at high-risk. Specifically, our recommendation is designed to ensure that medical providers have the most available information upon which to base their professional judgment. Based on the response, we request that the Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery address what provisions are being made to establish an overall standard command policy that is current and addresses medication management. This policy should include polypharmacy management, medication reconciliations, and pain management practices, including use of alternative therapies, that would provide appropriate direction for medical care providers, while still encouraging professional judgment and evaluation of specific patient presentation. We request that BUMED provide a response and timeline for updating such command policies.

Bureau of Medicine and Surgery Navy Pharmacy Consultant comments to recommendation *D.4.2.b.* are partially responsive. Based on management comments we have revised our recommendation. We acknowledge that there are other medical systems that provide similar capability. However, the Electronic Medication Management System was mentioned as an example because of its capability to limit the number of pills/capsules available to a Warrior at any one time, but also because of its beneficial utilization at some Army units. We request that the Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery respond to the revised recommendation, specifically, to the Electronic Medication Management System and/or other available systems being considered to support the wounded warriors' medication management needs, and to mitigate the risk of having large quantities of medications available to a Warrior at any given time. Furthermore, we request that an implementation timeline of a selected solution to this ongoing issue be determined.

Revised Recommendation

As a result of management comments, we revised draft Recommendation *D.4.2.b.* to include exploring additional methods that could assist in the proper dispensing of medications to Warriors. We request that the Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery provide a response to recommendation *D.4.2.b.*

D.4.2.b. Coordinate with the Wounded Warrior Regiment to determine if any available system designed to provide a safe method of dispensing of medications to patients would be appropriate, effective and practicable for use with Warriors assigned or attached to Wounded Warrior Battalions. While many systems might be available, one example of one such system might be the Electronic Medication Management System.

D.4.3. We recommend that the Commanding Officer, Navy Medicine East, develop and implement policy and procedures to ensure that there is a regularly scheduled and/or available procedure for discarding of Warriors unused and/or un-needed medications.

Bureau of Medicine and Surgery Comments

Bureau of Medicine and Surgery Navy Pharmacy Consultant, responding on behalf of the Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery and Navy Medicine East, concurred with comment to our recommendation. The Pharmacy Consultant explained that the Controlled Substances Act prohibits options concerning returns of unneeded medications, except to law enforcement personnel. The Consultant further explained that allowing patients to drop-off medications in a secure locked box is an option, but per regulations and consultations with the Drug Enforcement Agency (DEA), the box must be monitored and guarded 24 hours a day. The consultant went on to say that this severely limits accessibility for patients. The Consultant also explained that there is no lawful method for hospital or battalion staff to receive or “take-back” these controlled medications from patients, and that in previous take-back initiatives run by the Drug Enforcement Agency and local command, they have had extremely low participation rates. Furthermore, the Consultant noted that there are pending regulatory changes as a result of the Safe and Secure Drug Disposal Act that was signed into law on October 12, 2010, but until the proposed rulemaking is issued by the Attorney General, there is no process to follow.

Our Response

Bureau of Medicine and Surgery Navy Pharmacy Consultant comments are partially responsive. By concurring, BUMED has agreed to develop and implement policy and procedures to ensure that there is a regularly scheduled and/or available procedure for discarding of Warriors used and/or unneeded medications. We understand the limitations posed by the Controlled Substances Act, however, we request that additional comments be provided explaining how BUMED and/or Naval Hospital Camp Lejeune will develop and implement policy to ensure there is a process in place for Warriors to dispose of unused and/or unneeded medications.

D.4.4. We recommend that the Commanding Officer, Naval Hospital Camp Lejeune:

D.4.4.a. Update and implement local policies and procedures for overall medication management, to include polypharmacy management, medication reconciliations, to ensure that policies and procedures identify appropriate measures to mitigate any risk that results from the use of multiple medications which have the potential to result in adverse drug interactions if not monitored properly.

D.4.4.b. Update and implement local policies and procedures for overall pain management practices, to include use of alternative therapies.

Naval Hospital Camp Lejeune Comments

The Commanding Officer, Naval Hospital Camp Lejeune concurred with comment to our recommendations. The Commander explained that the pharmacy is leading a multidisciplinary team to evaluate the revisions that are needed to the current Naval Hospital Instruction 6710.5A, "Controlled Medication Utilization Review and Intervention Protocol," September 15, 2003. The Commander stated that the intent is to ensure Command guidance is given to providers and supporting staff in regards to narcotic and controlled medication prescribing and usage, preventing potential diversion or overuse, and providing strict guidelines for poly-pharmacy patients. He further explained that since a large majority of controlled medication prescribing is related to pain patients (patients with pain), a focus will be on this population which includes the Wounded Warriors. Additionally, the Commander noted that the established policies will be monitored and evaluated as dictated periodically utilizing easily retrievable CHCS reports measuring the program's effectiveness. The final proposed instruction is due to Naval Hospital Camp Lejeune leadership by April 1, 2012.

Furthermore, the Commander provided an update to the Naval Hospital Instruction 6320.55B, "Pain Assessment and Management," which was effective May 17, 2011.

Our Response

The Commanding Officer, Naval Hospital Camp Lejeune's comments are responsive and the actions meet the intent of the recommendations. No further action is required.

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Part III. Warriors Speak

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Warriors Speak: Comments from Wounded Warriors

We believe that it is important to give a voice to Warriors assigned to the WWBn-East. We felt that including comments made by Warriors themselves could best illustrate their various experiences in the unique development of the WWBn-East's mission and environment.

We interviewed 64 Marine Corps Active Component Warriors, both individually and in group settings at the WWBn-East. Those Warriors provided positive feedback in the following areas:

- Active Component Warriors received equitable access to medical care for the condition(s) that required their assignment or attachment to the WWBn-East at Camp Lejeune
- Warriors consistently reported excellent care and support from WWBn-East staff members, to include Recovery Care Coordinators, Transition Center staff, Platoon Sergeants, the Family Support Coordinator, and the Family Readiness Officer

We also noted fourteen common themes from Warrior interviews that we believe require the attention of management and staff from both the WWBn-East and the Naval Hospital Camp Lejeune. These fourteen common themes were categorized under one of the following four groups:

- Command Climate and Leadership
- Preparation for Transition
- Health Care Services
- Warrior Support and Services

Warrior Good News

Warriors that we interviewed during our visit provided positive feedback in two specific areas: equitable access to medical care and excellent support and services provided by the staff within the WWBn-East. This positive feedback is discussed below.

Equitable Access to Medical Care

An overwhelming majority of the Warriors that we interviewed stated that they received equitable access to medical care for the condition(s) that required their assignment or attachment to the WWBn-East.

As of September 13, 2010, there were 194 Marines assigned or attached to the WWBn-East at Camp Lejeune. Of those 194 Marines, none were activated Marine Corps Reservists. Between April 2007 and the end of our site visit, there have been a total of 10 Reservists that have transitioned through the WWBn-East. During our interviews, several Warriors commented that they were unaware that Reservists were even assigned to the WWBn-East as patients. When asked about equal access to medical care, among all Warriors combat versus non-combat in the WWBn-East. One Warrior specifically stated that their access to care is "absolutely equal."

Caring and Supportive Staff

Warriors consistently reported excellent care and support from WWBn-East staff, to include Recovery Care Coordinators, Transition Center staff, Platoon Sergeants, the Family Readiness Officer, and the Family Support Coordinator.

Recovery Care Coordinators stated that they were responsible for providing oversight of and assistance to the Warriors in numerous areas of their recovery and transition. Those areas included, but were not limited to, Comprehensive Transition Plan (CTP) development, financial counseling, spouse employment assistance, respite care information, and childcare assistance. Warriors described their Recovery Care Coordinators in the following ways:

- “Outstanding”
- “Best asset of the battalion”
- “A wealth of knowledge”
- “Probably the best resources we have”

During our site visit, the WWBn-East employed two Transition Coordinators who assisted with coordinating job fair information, resume writing classes, and employment opportunities for the Warriors. Transition Coordinators were lauded for their assistance to the Warriors. One specifically stated that his Transition Coordinator was “absolutely fantastic” and a “jack of all trades; phenomenal.” Another Warrior stated that the Transition Coordinators at the WWBn-East were really great and were helping him with federal-related opportunities. They counseled him about the National Reconnaissance Office and clearance opportunities, as well as the National Security Agency and related internship fairs.

Platoon Sergeants were also described by Warriors as helpful and “looking out for them.” One Warrior stated, and others agreed, that their main jobs were to keep accountability of them and make sure they made their appointments. Other Warriors commented that “the Platoon Sergeants are good at getting information to them and pointing them in the right direction if they need help,” and that “they have their Marines’ best interests at heart and help as much as they can.” One Warrior specifically added that his Platoon Sergeant “is a good guy and gets involved with the Marines. He used to be on active duty and knows that bullets don’t discriminate.”

Finally, Warriors also provided positive comments about the Family Readiness Officer and the Family Support Coordinator. The Family Readiness Officer was responsible for providing information to families, and for coordinating spousal support groups, luncheons, resiliency training for spouses, and briefings on available benefits. The Family Support Coordinator focused on families in the command that are in crisis. One Warrior commented that the Family Readiness Officer was really good. He stated that she contacted his wife and had gone on a five mile spouse’s walk to support them. Other Warriors commented that they and their families had utilized the Family Readiness Officer and/or the Family Support Coordinator for assistance.

Warriors' Concerns

There were several common themes we noted from our Warrior interviews. We believe that these concerns warrant the attention of management and staff in the WWBn-East and the Naval Hospital. Warriors' comments about those concerns are expressed in the following paragraphs.

Command Climate and Leadership

While some Warriors reported that the command climate appeared to be steadily improving, others reported that there were aspects of command climate and leadership that were hindering their recovery and transition. Specifically, some Warriors:

- Felt that the unit organization and barracks atmosphere were not always conducive to their healing and transition
- Reported inconsistent and ineffective communication throughout the unit, as well as potential Health Insurance Portability and Accountability Act of 1996 (HIPAA) violations
- Perceived that eligible wounded, ill, and injured Marines were not always accepted into the battalion
- Conveyed that good order and discipline were difficult to balance because of Warriors' drug problems and reckless behaviors
- Expressed concern that the command was not adhering to profiles and medical recommendations, risking further injury for Warriors

Environment in the Wounded Warrior Battalion-East

The themes of a negative command climate and poor treatment were evident during our Warrior interviews. Warriors we interviewed cited numerous and assorted examples of detrimental command climate and callous treatment that led to their anger, depression, frustration, and lack of motivation.

One Warrior's description of the environment at the WWBn-East was particularly alarming. When asked to clarify what stressed him out about being in the battalion, he said, "everything." He stated, "I'm treated like a criminal, they are suspicious of everyone, and you constantly have to prove yourself as if you are guilty until proven innocent. You're treated like you're lying about everything." He added, "They don't create an environment of comfort and happiness; they create an environment of stress and discomfort." He said that it's so bad, that guys in the barracks talk all the time that "someone is going to snap and kill themselves or someone else." Other examples of the negative climate and treatment included:

- One Warrior commented that the barracks were a depressing place and a lot of the guys were depressed.
- Another Warrior stated that the battalion was chaos and the drug issue was out of control. He thought that the reason nothing was done to the guys caught with drugs was because no one wanted to be the guy that kicked out a Marine for drugs. He added that the Warriors used their conditions as an excuse for their behavior. He also said that the field day on Thursdays was borderline hazing because of the way the guys were treated.

- A third Warrior stated that they needed to provide a friendlier, more peaceful environment because “90 percent of the problems are created by stress.” He added that “everyone seems so depressed, angry, and stressed, and they just want to get out of here.”
- During a group interview, the Warriors agreed that the WWBn-E had a negative attitude and it was best to stay away as long as and as much as possible. One group member added, “If I stick around the barracks I’ll turn to shit.” The non-combat wounded are like all the bad eggs in one basket; like what happens in prison.”
- Finally, a Warrior stated that there is a “prison mentality” here and many of the guys here cannot see the “forest through the trees” in terms of their futures. He added that there is a lot of misery in the barracks and bad attitudes can get passed around like a cold. He stated that the leaders have to keep a close eye on everyone, and that often does not help Marines in their recovery.”

How units were organized within the WWBn-East was also a point of contention among interviewed Warriors. Several Warriors adamantly stated that combat wounded and non-combat wounded should be in separate units. One Warrior stated that it was a bad idea that non-combat wounded had access to some of the services provided (such as hunting trips), thus reaping the rewards the combat wounded have earned. He felt it diminished their sacrifice and that separate units should be formed under separate commanders.

Another Warrior stated that the combat experienced and wounded guys should be in their own platoon. His rationale was that combat guys needed to be looked at for combat stress. A Warrior who was combat wounded in Afghanistan stated that the combat wounded need to be separated from the non-combat wounded, especially those that were severely wounded in combat. He said, “I feel as though I have been lumped in with the guys that are here as malingerers and are taking up the resources being provided for those with legitimate injuries like mine.” Finally, when discussing unit organization, a Warrior stated, “They are missing unit cohesion, which is why the combat guys hang together because they can relate to each other. Unit organization is good for Marines because they understand squads and platoons. These guys need structure.”

Communication within the Wounded Warrior Battalion-East

We were told about several instances of inconsistent and ineffective communication within the WWBn-East. These instances explained by Warriors mostly consisted of failures to obtain information in a timely manner and are depicted in the following.

- “The battalion needs to “provide information on internship and employment opportunities [because] this information is not disseminated at formations.”
- “Warriors need to receive more information from the battalion about benefits that are available to them, such as Traumatic Service members’ Group Life Insurance.”⁴²
- “There are a lot of last minute things that come up and they aren’t fully communicated;” (for example, he had no idea why he was being interviewed today).

⁴² Traumatic Service members Group Life Insurance provides for payment to any member of the uniformed services covered by Service members’ Group Life Insurance who sustains specific catastrophic injuries.

- “There are a lot of services here and no one seems to understand what all is available. There are communication gaps and challenges and that leaves people frustrated.”
- “I feel like the command is organized but I don’t find out information until the last minute. The word is not getting out.”

Also brought to our attention during Warrior interviews was the possibility that HIPAA violations were occurring amongst battalion staff. Multiple Warriors made comments, such as:

- A Warrior commented that “confidentiality of personal information is an issue.”
- Another Warrior stated during his interview that [a staff member] tells the Warrior “all kinds of things” and he thinks [the staff member] is violating HIPAA by doing so.
- A third Warrior stated, “There is sometimes a privacy issue in the battalion, but it depends on the issue.”
- A Warrior informed his interviewer that he did not sign any release forms, yet his doctors (at the Military Treatment Facility) released his records, which in his opinion was possibly a HIPAA violation.
- Finally, a Warrior mentioned that privacy issues are a big problem in the unit. First, nurse case managers “say things” and it is not hard to figure out who they are talking about, which he thinks is a HIPAA violation. Second, he stated that [another military staff member] will say something about a Warrior needing an appointment and will give the Warrior that provider’s appointment sheet to sign up for an appointment. This allows the Warrior to see every other Warrior that already has appointments scheduled with that provider.

Eligibility of Warriors in the Wounded Warrior Battalion-East

Warriors perceived, and we were told, that Marines may have been assigned or attached to the WWBn-East although they may not have been eligible. Additionally, some Warriors were particularly concerned that the title of “Wounded Warrior Battalion” was misleading because the unit was full of those who were not wounded in combat.

When asked why he was in the WWBn-East, a senior enlisted Warrior informed his interviewer that because he needed surgery on his knee and was retiring by the end of the year, he decided to transfer to the battalion so he could free up a slot in his old unit. He stated that this slot was important to his old unit because they were getting ready to deploy. Another Warrior stated that entry into the battalion should be out of the battalion command’s control and that an independent and objective monitoring process should be in place to avoid “cherry picking” Wounded Warrior entries. Finally, during a group interview, Warriors indicated that they needed better screening of Wounded Warriors, and that for example, a triage approach for entry into the battalion might eliminate Marines who may not need to be there. The Warriors explained that some Warriors “come in with a broken arm and leave with PTSD.”

Additional comments from Warriors included:

- “The battalion is full of a lot of non-combat guys. It was originally set up as a Wounded Warrior battalion, but that is misleading because so many guys aren’t ‘Wounded Warriors.’”

- “Veterans groups get upset when they come here and find other than combat wounded assigned to the Wounded Warrior Battalion. They need to change their name to something other than Wounded Warriors because that is not what the unit truly represents.”
- “When you hear the title of Wounded Warrior Battalion, what do you think of? A guy that broke his pinky or a guy that was wounded during war. If there were more Wounded Warriors, this would be a good unit. It has swayed so far from what it was stood up to be, and they are trying to run it like a regular unit when it is supposed to help wounded guys heal and rehabilitate.”
- “Wounded Warrior screening should be formal and with clear eligibility criteria; in other words, eliminate the “old boys” network.”
- “The Wounded Warrior battalion used to be a prestigious unit but now it is a dumping ground. I estimate that only 10 percent are combat wounded...the real combat wounded will not come to the Wounded Warrior battalion because of its stigma. It is an embarrassment to be in the Wounded Warrior Battalion-East because it has become a place for lazy Marines to get into and sit around.”

Good Order and Discipline

The Warriors expressed concern with the administration of discipline within the battalion. Some felt that the discipline was inconsistent, and that the punishment did not always fit the crime. Specific comments from Warriors concerning the order and discipline within the unit included, but were not limited to the following:

- One Warrior stated that the battalion needed more consistent discipline. He said that non-drug offenses (e.g. theft) may lead to discipline and a possible loss of benefits, while drug use was not punished as it would be in a regular unit.
- Another Warrior stated that the command let everyone get away with murder because they are taking sympathy on them [the Warriors]. He added, “Guys are selling illegal drugs (heroin, cocaine, marijuana)...but there was no action taken because the battalion protects them. While they stick up for the drug addicts, they will nail you to the wall for missing an appointment or formation or for sleeping in and missing something because you are on sleep meds. It’s backwards.”
- A third Warrior added, “The Marine Corps hammers drug users in other units and there should be no difference here. I am not talking about a guy that gets hooked on his medications. Instead, I am talking about the illegal drug user who uses his wounds to hide his habits.” He believed that the reason the command did not crack down harder was because of political pressure.
- Another Warrior understood that being too strict could negatively affect the “truly injured,” but believed that the punishment should still reflect the crime regardless of the fact that the Marine was in the WWBn-E.
- A Warrior added, “There are often people screaming at Marines who make mistakes and the leaders will jump down their throats. A guy who forgets to put a mop away should not be yelled at when he has PTSD/TBI. He probably just forgot.”
- Finally, a Warrior stated that he was disappointed in the use of drug waivers, and that there was no accountability or consistency in how the drug abusers were dealt with. He

said that even after four or five positive drug tests, the command wouldn't take rank or pay away from them.

Adherence to Medical Profiles and Recommendations

Warriors assigned to the WWBn-East were assigned military duties that they performed in addition to their medical processing, appointments, and military formations. They expressed concern that due consideration to individual Warrior medical conditions was not given in developing those duty assignments. Their comments included:

- A Warrior explained that having duty was stupid. He said that his profile said that he was on limited duty from 9:00 a.m. to 4:00 p.m. and had no night duty, but he was required to pull night duty, which required him to sleep in the barracks. He added that sleeping in the barracks was hard for him to do without his sleeping pill, and in a strange environment.
- Another Warrior explained that every Thursday they had to report at five o'clock for field duty to mop and vacuum. He said that there were guys on crutches that were vacuuming and guys with bad backs on their knees scrubbing base boards. He concluded "It's almost like hazing."
- A third Warrior provided that field day on Thursdays is at 5:00 p.m., "and this is stupid. They [the command] think that making it later will enable guys to be there because they are done with appointments, but guys still don't show." He said that technically, most guys' paperwork says "limited duty," which means no cleaning or duties, but the command makes them participate anyway.
- Another Warrior added that field day on Thursdays where they clean was stupid. He said that he didn't mind cleaning, but he would go in an air cast and they wanted him to participate, so he was moving boxes while on crutches. He said that the command told them, "don't use your disability as a crutch," but he wondered what were you supposed to do when you actually were on crutches?
- Finally, a Warrior stated that a lot of guys drove while medicated; for example, he used to drive while on sleep medications around 6:00-6:30 a.m. for formations. He said that the doctors would tell them to do one thing (take your sleep medications at nine or ten in the evening), but the battalion would tell you to do another (be in formation by 7:00 a.m.).

Preparation for Transition

With regard to preparing for their transitions, Warriors largely:

- Varied on participation in transition activities and claimed they needed more vocational rehabilitation, such as internships, to assist with their transition to civilian life
- Did not recognize that they completed a Comprehensive Transition Plan to assist with their transition from the WWBn-East

Activities to Prepare for Transition

Preparation for a successful transition whether returning to duty in the same career field, returning to duty in a new career field, or returning to civilian life as a productive member of society, was on the minds of the majority of Warriors we interviewed. For many of those Warriors, the military and their career field was all the way of life and work they had known.

For those who could no longer carry out their duties in the Marine Corps due to their condition or injuries, their concern about acquiring new skills and training to prepare for the future either in the military or in the civilian world dominated their thoughts.

Warriors' comments regarding their transition activities mostly in preparation for civilian life included but were not limited to:

- A Warrior stated, "They [the command] have great intentions but they need to realize that everyone's goals are different. They need to treat us as individuals and that is something for Marine Corps leaders to understand. Any sort of mandatory approach to anything here will be met with resistance from the wounded. College kids need to work on college and the other guys who need work need to work on their resumes. It is really that simple."
- Another Warrior stated that the battalion was doing more to transition them into civilian life, to include resume writing and job fairs, but was doing nothing for college preparation.
- A Warrior added that the climate that promoted going to school started about one month prior to our visit. He added that prior to that, the only schooling that was promoted was resume writing classes.
- Another Warrior stated, "Many folks here miss the point. I needed to know what is wrong with me before they tell me to get a [sic] resume! The rules of engagement here are like the battlefield in Afghanistan. They don't know what they are doing, so they deal with everyone like we are "boots" and expect everything to work out in the end. It is terrible."
- A Warrior was confused as to whether he would return to duty or medically retire, stating, "Right now I am lost and confused. I do not know what the future holds and I need someone to help me sort all of this stuff out."
- A Warrior stated that he had not started to take courses while at Camp Lejeune because he thought the process would not allow him time to complete them. He stated that he wished they would allow him to be at home so he could start college while calling in or something else for accountability. He stated, "Being at the battalion at a low level of activity is not really helpful or necessary."
- Finally, a Warrior stated that he would rather be occupied. He added that he would also like to look for a paying job so he could purchase a house, but another Warrior killed that opportunity for everyone by getting fired from his job and not letting anyone know what he was doing for three months.

Comprehensive Transition Plans

The primary tool used to coordinate a recovering Marine's and their family's care is the CTP. The CTP is based upon information from the Marine's recovery needs assessment, which is developed with the help of the Recovery Care Coordinator and takes into consideration various components such as employment, housing, financing, counseling, family support, the disability evaluation process, and more. The CTP is owned by the Marine and is aptly referred to as a "life map" for the recovering Marine and family. It reflects their medical and non-medical goals and milestones from recovery and rehabilitation to community reintegration.

While it appeared that Warriors were discussing their medical and non-medical goals and milestones with their Recovery Care Coordinators, many of them were not aware that these discussions were in support of their own CTPs. In addition, many Warriors claimed that their Recovery Care Coordinators were completing their CTPs for them, essentially releasing the Warriors from taking ownership of their CTPs and goals. With regard to the CTP, Warriors provided the following comments:

- One Warrior stated that he was “pretty sure” he had heard of the CTP. He said that he and his Recovery Care Coordinator just started it about a week ago.
- Another Warrior said that he worked with his Recovery Care Coordinator on different things (for example, she provided him with job opportunities), but he was not sure if what they did was called a CTP.
- A third Warrior stated that he wasn’t sure if he had a CTP, but his Recovery Care Coordinator did talk to him about his goals.
- A Warrior stated that he had never heard of a CTP, transition plan, or 18-month plan, but said that his Recovery Care Coordinator talked to him about his goals.
- Another Warrior stated that he didn’t have a CTP and wasn’t aware of what a CTP was.
- When asked if he created his own CTP, a Warrior answered, “I am unsure of what this is. I think the Recovery Care Coordinators do this for us.”
- Another Warrior answered similarly to the same question, stating, “I am not sure if I have a CTP. I believe the Recovery Care Coordinator does this for us. I am not sure.”

Health Care Services

There were multiple health care-related issues discussed in previous Observations that were also addressed by Warriors. Warriors specifically reported concerns about access to specialty care among other issues. Warriors:

- Reported that access to specialty care (such as mental health, neurology, and orthopedics) was not always timely
- Provided mixed reviews about the abilities of and access to their Medical Case Managers
- Expressed concerns with pain management, specifically that Primary Care Managers were not supporting their pain management needs

Access to Specialty Care

Warriors reported that they were not receiving timely access to certain types of specialty care. Access to neurology and mental health appeared to be the most challenging. Additional comments from Warriors about access to specialty care included, but were not limited to the following:

- A Warrior reported that it could take a month and a half to get an appointment. He also stated that his psychiatrist would not refer him out even if appointments were not obtainable. He said that his care was basically taking medications, with no other therapy or resolution of problems (such as his anxiety).
- A second Warrior stated that appointments for neurology took a month, and for psychologists/psychiatrists about two weeks.
- Another Warrior stated that it took an “act of Congress” to get an appointment with his neurologist. He added that even follow-up appointments took two months. He said he

believed they were short staffed, and to his knowledge, they were not referring Warriors downtown for neurology.

- During a group interview, three members of the group stated they needed neurology appointments once per month at a minimum, but could only get an appointment every two to three months.
- A Warrior noted that although he was no longer receiving care, when he did have to see orthopedics, neurology, and physical therapy, it took a long time to get appointments.
- Another Warrior added that it usually took one to two weeks for him to get a physical therapy appointment and up to one month for a pain management appointment.
- A Warrior who was transferred from Bethesda Naval Medical Center to Camp Lejeune stated that at Camp Lejeune, it took two to three weeks for a psychology appointment and anywhere from three weeks to one month for an appointment with a psychiatrist.

Medical Case Managers

Warriors provided mixed reviews about the quality and accessibility of their medical case managers. Some Warriors stated that they found them to be helpful, providing examples of how they helped them or expressing appreciation for their expertise and dedication.

- One Warrior said simply, She “gets things done.”
- Another said his medical case manager “helped prepare an MEB [Medical Evaluation Board] packet in record time.”
- One said his had “helped with everything through twenty surgeries.”
- Other expressions of praise by various Warriors included: “great,” “awesome,” “amazing,” “trustworthy,” and “living encyclopedias.”

Other Warriors seemed to run into conflicts or personality clashes with their medical case managers, and expressed that their primary concern was lack of accessibility, to include their hours of availability. Other concerns included:

- During a group interview, one Warrior stated, “Often we need an appointment now. They aren’t available enough. They are closed Wednesday afternoon until Friday, and are only open from nine a.m. until three p.m.”
- Another Warrior shared, “You have to get an appointment to see them.”
- When discussing medical case managers, another Warrior added that they have “no walk in or open door policy.”
- As far as accessibility, another Warrior added during a group interview, “They need a phone line, an assistant, or somebody to answer the phone.”

Pain Management

During individual interviews, Warriors expressed concerns with pain management; specifically, that their primary care managers were not supporting their pain management needs. Warriors’ biggest concerns were that they felt they were not able to get the pain management care they needed.

During an individual interview, one Warrior bluntly explained, “There is a pain management issue in the battalion. Guys are seeking illegal and other prescription meds to cope, but the

command sweeps the drug issues under the rug. Since there is a big drug problem, if you go to [the primary care manager] and ask for drugs because you are in pain, he won't give meds because he thinks you will sell or snort them.”

Other Warriors' comments included:

- One Warrior stated that he refused to see his primary care manager because he called him a “druggie.” He instead considered his pain management doctor as his primary care manager, whom he really liked because he believed in alternative means of therapy, instead of popping pills.
- Another Warrior stated that his primary care manager challenged his diagnoses and didn't like to give out medications because other guys were abusing; in other words, the primary care manager's philosophy was “don't give any medications to anyone.”
- A Warrior felt he was not getting assistance with his pain management needs because of previous problems he encountered. He admitted testing positive for illegal drugs in the past, but claimed that he was taking illegal drugs to help control his pain. He noted, “Once you get in trouble [for illegal drugs] you can never get away from that stigma.” He stated that he had asked for help, but they accused him of shopping for medications. He concluded that he felt his primary care manager assumed he was abusing medications and therefore, was blocking his access to medications to manage his pain.
- Another Warrior also had an issue with his primary care manager questioning his medications. He provided an example of his doctor questioning his use of a specific medication even though he was dealing with a very personal and difficult issue.
- Finally, a Warrior explained that he was taking five to six different medications prescribed by multiple doctors. They wanted him to see pain management, but he stated that since he'd heard nothing but bad things about pain management, he had been avoiding making an appointment.

Warrior Support and Services

There were multiple areas where Warriors believed that they were not receiving the support and services necessary to assist with timely recoveries or successful transitions. Specifically, Warriors:

- Expressed concerns with the Warrior Athlete Reconditioning (WAR)⁴³ program to include mandatory participation and implementation issues
- Reported that assignment to the WWBn-East limited promotion opportunities
- Provided numerous issues with their medical board processing, to include incomplete, untimely, expired, and invisible medical packages; problematic physician dictations; and frustrations with medical board counselors
- Provided that they did not have priority for or constant support from certain services, to include daycare, appointments, or duty drivers

⁴³ The WAR program was established as a reconditioning program for the Marines, and to help provide a purpose for, improve the health of, and instill pride in each Warrior.

Warrior Athlete Reconditioning (WAR) Program

Warriors in both individual and group interviews overwhelmingly reported that they had concerns about the implementation of the WAR program within the WWBn-East.

A senior enlisted Warrior explained, “As far as the WAR program, because it is mandatory, they [the Warriors] will push away. The intent of the WAR is to heal, but now the Warrior’s job is to bicycle, swim, or kayak, etc. This is not reality.” He added that by making the WAR program mandatory, the battalion was creating a counter-productive end state, stating, “Why would you leave if you get a full paycheck and ride horses all day?” Finally, he explained that the battalion “swapped priorities” because they allowed WAR activities to interfere with their medical care. Specifically, he stated that Warriors could put off appointments to attend other activities, such as the WAR games or cycling events. Another Warrior agreed that the battalion had swapped priorities as he was told that WAR activities would trump his physical therapy if there was a scheduling conflict.

Other Warriors who were concerned about WAR implementation specifically commented about the requirement for mandatory participation. Specifically:

- A Warrior felt that the WAR program was “dumb.” He stated that he had two bad legs, a bad back, a stimulator in his back, and balance problems, and didn’t feel he could do much of anything, but the WAR had become a mandatory program after the Warrior games. He added, “They need to stop forcing guys to do what they [the command] want not what the Warriors want.”
- Another Warrior mentioned that the WAR program should not be mandatory because “as soon as you make it mandatory, guys don’t want to do it anymore.”
- When asked about the WAR program, a Warrior stated that he initially enjoyed it when it was a voluntary program, but since it became mandatory, he chose not to participate. He stated that he was much more comfortable doing physical training on his own and didn’t want to be forced into classes he didn’t want to take.
- During a group interview, Warriors stated that WAR participation could lead to injuries and delay their medical boards. They added that the battalion should conduct a needs assessment of Warriors’ conditions before making WAR participation mandatory, and if the Warrior was fit and not overweight, that Warrior should be excused.
- During a separate group interview with Warriors, group members agreed that a lot of the Marines were afraid of incurring another injury as a result of WAR activities.
- Another Warrior added, “The WAR program being mandatory is probably a bad idea and will be met with resistance from the Marines in the program. I lost 36 pounds in the WAR program, so for me it worked. But others are already complaining about the program itself, all because of the mandatory application of it.”
- A Warrior stated, “One size does not fit all and the WAR program becoming mandatory is terrible. They are trying to run this unit like a regular unit and that is not the right thing to do.”
- Another Warrior commented, “They could not make the WAR program mandatory. I am concerned that I will further injure myself if I am forced to participate.”

- Another Warrior said that some of the guys were complaining that the WAR program was contradictory. “It says don’t PT on your profile, but the battalion expects you to row a kayak.”
- A Warrior added that he was concerned about the WAR program because they made certain things mandatory. He added that he would rather work out on his own in the gym because he was tired of the pool and it was not doing much for his weight gain. He stated, “The bottom line is that there shouldn’t be a forced requirement; we should get the opportunity to choose.”

Promotion Eligibility

Another area of concern for Warriors was that once they entered the WWBn-East, their opportunities for promotion seemed to come to a halt. One Warrior even considered his assignment to the WWBn-East as a “career ender.” Additional comments from that Warrior, and others, are as follows:

- That Warrior added that he felt “forced out” of the Marine Corps and the WWBn-East. He believed that being in the WWBn-East screwed up his proficiency and conduct marks.⁴⁴ He said that in his previous units he used to get high marks, but had received lower marks in the WWBn-East. He stated that he had no idea why he got such low marks, and it had hindered his promotion potential.
- Another Warrior stated that since he was injured, he was unable to conduct his fitness test, and as a result, was also unable to get promoted to the next rank. He felt that he was a “stellar Marine” before his accident and he now would be unable to get promoted to a corporal. He felt like his unit sent him to the WWBn-East and forgot about him. He stated, “At least if I had a goal like being able to pick up rank, I’d have something to push for while I’m here...I’m still a Marine and did not come here to give up.”
- A third Warrior stated, “I do not want to transition. I want to get promoted. I cannot get promoted because I am an injured guy. I also cannot get my fitness report completed and I will have a one year gap in my record since I have not had one for a while. I cannot get promoted in the Marines until I leave the Wounded Warrior [battalion]. It seems to me that there should be a provision for guys wounded in combat to be seen by the boards and not penalized for having recovery time. That is what I would like to see happen.”
- Finally, a Warrior stated, “I cannot get promoted meritoriously, so my career is largely over since I cannot PT or fire a weapon.”

Medical Board Processing

Multiple Warriors in the WWBn-East complained about certain aspects of the Medical Evaluation Board⁴⁵ process, to include incomplete, untimely, expired, and invisible medical

⁴⁴ Proficiency and conduct markings are assigned for Marines in the grades of private through corporal. These marks record the Marine’s performance, which is used to determine eligibility for reenlistment, qualification for certain types of duty assignments, characterization of service upon discharge, and computation of composite scores for promotions.

⁴⁵ A Medical Evaluation Board is a panel of providers at a Medical Treatment Facility who prepare a Medical Evaluation Board report that verifies whether a Service member is fit for duty or refers the case to a Physical Evaluation Board for disability or fitness determination for continued service.

packages; problematic physician dictations; and frustrations with medical board counselors. Additionally, multiple Warriors appeared frustrated because expired packages resulted in them going through the medical board process a second, and sometimes even a third time.

Additional comments from Warriors in both group and individual interviews included:

- During a group interview a few Marines stated that their biggest worry was the medical board process, and added that a huge problem included the “multiple expirations” of medical boards. They provided an example of one Marine who had been at Camp Lejeune for four years because of medical board expirations. One Warrior in the group stated that his board expired three times, and he was three days [from the date of our interview] from a fourth medical board expiration. Another Warrior stated that his board was also on the verge of expiring and it was being processed regardless of its completeness and correctness.
- Another Warrior stated, “Teach people to understand what will make a good medical board package. The medical board counselors are the single point of failure, so they must be experts in this job. Don’t just hire anyone...it is too critical. Maybe they could contract experts to do this so we don’t get messed up like others have in the past.”
- A Warrior stated that his first Medical Evaluation Board packet expired because his counselor, whom he called “no action Jackson,” did not properly communicate the requirements for his package. He added that this was a common problem with at least five other Warriors whose packets expired without notice.
- Another Warrior stated that he was concerned that his medical board package would expire in December while he waited for the battalion leadership to finish part of their paperwork. He added that his medical board counselor was “absent” – he didn’t receive phone calls from him, and he was not personal or timely. He said that he was waiting on his medical board counselor, and there were other guys “in the same boat.”
- Another Warrior stated that his medical board package was delayed because the board would not accept civilian dictations and he had to have them redone.
- A Warrior explained that his medical board packet required a letter about items in his packet nearing expiration, but there were no significant changes. After going through the hoops to get the letter, he found out that the letter was never sent and no one in the battalion took ownership for the omission. He said he restarted the medical board process in April 2010, including getting updated medical appointments at both Camp Lejeune and the DVA. He said that although he didn’t know what the Medical Evaluation Board counselor did, the battalion command blamed that counselor for the lapse of his medical board.
- Another Warrior explained that he originally completed the medical board process in April [2010], but the medical board counselor didn’t mail his package, so he had to retake some of the tests because they expired. He said that he had to redo his neuropsychology test, get a new mental health dictation, and a new neuropsychology dictation because they all expired. He stated that because they are “screwing around with his medical boards,” he missed out on an opportunity to work with an Army General in a job that could likely

translate to federal employment. He suggested, “Maybe they should dedicate one or two medical board counselors to the WWBn to take care of the Warriors since most of them will medically retire.”

- Finally, a Warrior simply stated, “The Medical Evaluation Board process is too slow.”

Support Services for Warriors

Several Warriors also added that they did not receive priority for, or get consistent support from, certain support services. Those support services included, among others, daycare, appointments, and duty drivers. Comments from Warriors included:

- A Warrior provided that the Warriors in the WWBn-East did not get precedence for day care. He stated that his wife worked, he was on sleep medications, and because they were struggling financially, they just received additional federal assistance to make ends meet.
- Another Warrior, while providing that he wished there was marriage counseling available on base, also provided that he would like to see child care made available.
- A third Warrior stated that he would like to see more help with the availability of child care. He said that the drop-in daycare at Camp Lejeune wasn’t always available when they needed it.
- A Warrior stated that he had medical appointments in Greenville, North Carolina, and had asked for a duty driver. The duty driver never showed up so the Marine drove himself instead of missing his appointment(s), although he was not supposed to drive in unfamiliar areas because of his TBI and PTSD.
- During a group interview, a Warrior stated there was no priority for members of the WWBn-East when scheduling appointments.
- Finally, a Warrior also stated that parking was an issue. He said that they used to have stickers for their cars for WWBn-East parking, but the command didn’t enforce parking anymore. He said that others who go to the gym or sports medicine clinics park in their WWBn-East parking lot, resulting in “broken” guys having to park further away to get to their barracks.

Conclusion

Warriors provided good feedback about their access to medical care and excellent support and services provided by WWBn-East staff. However, they also expressed concerns about certain aspects of their recovery and transition that we believe warranted specific mention. Because several of these themes were addressed in previous Observations, we are not making formal recommendations about the Warriors’ concerns expressed in this section. However, we do recommend that management and staff from the WWBn-East and the Naval Hospital review the concerns voiced by Warriors to more effectively support their healing and transition.

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Appendix A. Scope, Methodology, and Acronyms

We announced and began this assessment on April 16, 2010. The assessment was planned and performed to obtain sufficient evidence to provide a reasonable basis for our observations, conclusions, and recommendations, based on our objectives. The team used professional judgment to develop reportable themes drawn from multiple sources, to include interviews with individuals and groups of individuals, observations at visited sites, and reviews of documents.

We visited the Wounded Warrior Battalion – East (WWBn -East), and the Naval Hospital located at Camp Lejeune, North Carolina, from September 20 thru September 30, 2010. During our 2-week site visit to that location, we observed battalion operations and formations; viewed living quarters, Battalion and Hospital facilities, and selected operations at the medical center; and examined pertinent documentation. We also performed meetings and interviews – ranging from unit commanders, staff officers, to civilian staff and contractors, as shown below:

- Battalion Commander and Command Sergeant Major
- Battalion Primary Staff
- Company Commanders
- Platoon Sergeants
- Warrior Athlete Reconditioning Program Director
- Charitable and Veterans Service Organizations Program Coordinator
- Recovery Care Coordinators
- Transition Center Staff
- Call Center Director
- Family Readiness Officer
- Family Support Coordinator
- Disability Evaluation System Attorney
- Families of Recovering Service Members
- Primary Care Manager
- Medical Case Management Advisor
- Medical Case Managers
- Battalion Chaplain
- Traumatic Brain Injury Clinic Staff
- Behavioral Health Clinical Psychologists
- Pharmacy Staff
- Hospital Commander
- Directors of the Hospital
- Licensed Clinical Consultant
- Physical Evaluation Board Liaison Officer
- Senior Medical Department Representative
- Career Planner
- Patient Administration Staff

Further, we performed interviews with WWBn-East recovering Marines, to include 64 individual interviews with randomly selected Marines, and 4 group interviews with additional Marines grouped by rank.

We prepared standardized sets of questions that were used during individual and group sessions, which were tailored to the type or group of personnel being interviewed. Those interviews included, but were not limited, recovering Marines, Recovery Care Coordinators, Platoon Sergeants, Primary Care Manager, and Medical Case Managers. The standardized interview questions for these groups included topics such as: access to care, use of Comprehensive Transition Plans, responsibilities for staff members, working relationships, and discipline issues within the WWBn-East, among others.

Use of Technical Assistance and Computer-Processed Data

The DOD Office of the Inspector General, Deputy Inspector General for Audit, Quantitative Methods and Analysis Division, used a simple random sample approach to determine the number of recovering Marines we should interview at the Camp Lejeune WWBn-East to obtain a representative sample. The random sample was used to avoid any biases that might have been introduced by selecting interviewees non-statistically.

The analysts used an alpha roster provided by the Battalion that; identified by name, rank, and WWBn-East company assignment. As of September 13, 2010, there were 194 Marines at the Camp Lejeune WWBn-East, comprising the total population from which we drew our random sample.

The analysts used a program called the Statistical Analysis System and its internal random number generator to assign random values to each individual, then sorted all 194 Marines into random number sequence. Using this method, the analysts calculated a sample size of 51 Warriors for individual interviews. The sample size is based on a 90 percent confidence level, a planned margin of error of 10 percent, and the statistically conservative assumption of a 50 percent error rate.

The team used this approach to first determine whether any reportable themes (noteworthy practices, good news, issues, concerns, and challenges) were identified by those most impacted by their assignment to the WWBn-E, the recovering Marines. We met with or interviewed others – ranging from, unit commanders, staff officers, and cadre, to civilian staff and contractors – to corroborate the identified themes or to identify other reportable themes not readily known to the Warriors.

On September 15, 2010, we provided the list of Warriors to be interviewed from our randomly generated sample to WWBn-East. With a requirement of 51 interviews, we selected the first 64 from the randomized roster and sent them to the Battalion to fill the names into the available time slots. If the Battalion was unable to fill all time slots due to a Marine being unavailable we provided additional names as needed until the roster was full. We advised the Command that a justification must be provided for any individuals in that sequence that were unable to attend an interview. Below are the results from our Warrior's individual interviews at WWBn-East.

Of the 64 Warriors statistically selected:

- 52 Primary were interviewed
- 11 Designated alternates were interviewed
- 14 were excused
- An additional Marine was interviewed that was not in the provided list

The Battalion produced or excused all of the required Marines shown in the randomly selected sample. We believe that the information obtained from the 64 individuals selected as part of our random sample provided an indication of the views of the total population.

Acronym List

The following acronyms were used in this report.

AHLTA	Armed Forces Health Longitudinal Technology Application
CHCS	Composite Health Care System
CONUS	Continental United States
CTP	Comprehensive Transition Plan
DES	Disability Evaluation System
DVA	Department of Veterans Affairs
EMMA	Electronic Medication Management System
HIPAA	Health Insurance Portability and Accountability Act
IDES	Integrated Disability Evaluation System
LPN	Licensed Practical Nurse
MCM	Medical Case Manager
MEB	Medical Evaluation Board
MTF	Military Treatment Facility
NCO	Non-Commissioned Officer
PCM	Primary Care Manager
PEB	Physical Evaluation Board
PTSD	Post-Traumatic Stress Disorder
RCC	Recovery Care Coordinator
SARP	Substance Abuse Rehabilitation Program
SNCO	Staff Non-Commissioned Officer
TBI	Traumatic Brain Injury
UCMJ	Uniform Code of Military Justice
VA	Veterans Administration
WAR	Warrior Athlete Reconditioning
WW	Wounded Warrior
WII	Wounded Ill and Injured
WWBn-East	Wounded Warrior Battalion East
WWBn-West	Wounded Warrior Battalion West
WWR	Wounded Warrior Regiment

Appendix B. Summary of Prior Coverage

During the last 6 years, there has been a multitude of prior coverage on DOD and Department of Veterans Affairs (DVA) health care services and management, disability programs, and benefits. The Government Accountability Office (GAO), the Department of Defense Inspector General (DOD IG), and the Naval Audit Service have issued 10 reports specific to DOD Warrior Care and Transition Programs. Unrestricted GAO reports can be accessed over the Internet at <http://www.gao.gov>. Unrestricted DOD IG reports can be accessed at <http://www.dodig.mil/PUBS/index.html>. Naval Audit Service reports are not available over the Internet.

GAO

GAO Report No. GAO-12-27R, “DOD Mild Traumatic Brain Injury,” October 24, 2011

GAO Report No. GAO-12-129T, “DOD and VA Health Care: Action Needed to Strengthen Integration across Care Coordination and Case Management Programs,” October 6, 2011

GAO Report No. GAO-11-551, “Defense Health Care: DOD Lacks Assurance that Selected Reserve Members Are Informed about TRICARE Reserve Select,” June 3, 2011

GAO Report No. GAO-11-572T, “Federal Recovery Coordination Program Enrollment, Staffing, and Care Coordination Pose Significant Challenges,” May 13, 2011

GAO Report No. GAO-11-633T, “Military and Veterans Disability System: Worldwide Deployment of Integrated System Warrants Careful Monitoring,” May 4, 2011

GAO Report No. GAO-11-32, “VA Health Care: VA Spends Millions on Post-Traumatic Stress Disorder Research and Incorporates Research Outcomes into Guidelines and Policy for Post-Traumatic Stress Disorder Services,” January 24, 2011

GAO Report No. GAO-11-69, “Military and Veterans Disability System: Pilot Has Achieved Some goals, but Further Planning and Monitoring Needed,” December 6, 2010

GAO Report No. GAO-09-357, “Army Health Care: Progress Made in Staffing and Monitoring Units that Provide Outpatient Case Management, but Additional Steps Needed,” April 20, 2009

GAO Report No. GAO-09-31, “Defense Health Care: Additional Efforts Needed to Ensure Compliance with Personality Disorder Separation Requirements,” October 31, 2008

GAO Report No. GAO-08-635, “Federal Disability Programs: More Strategic Coordination Could Help Overcome Challenges to Needed Transformation,” May 20, 2008

GAO Report No. GAO-08-615, “DOD Health Care: Mental Health and Traumatic Brain Injury Screening Efforts Implemented, but Consistent Pre-Deployment Medical Record Review Policies Needed,” May 30, 2008

GAO Report No. GAO-08-514T, “DOD and VA: Preliminary Observations on Efforts to Improve Care Management and Disability Evaluations for Servicemembers,” February 27, 2008

GAO Report No. GAO-07-1256T, “DOD and VA: Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers,” September 26, 2007

GAO Report No. GAO-06-397, “Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers,” May 11, 2006

DOD

Department of Defense Recovering Warrior Task Force, 2010-2011 Annual Report, September 2, 2011

DOD IG

DOD IG Report No. SPO-2011-010, “Assessment of DOD Wounded Warrior Matters – Fort Drum,” September 30, 2011

DOD IG Report No. SPO-2011-004, “Assessment of DOD Wounded Warrior Matters – Fort Sam Houston,” March 17, 2011

DOD IG Report No. IE-2008-005, “DoD/VA Care Transition Process for Service Members Injured in Operation Iraqi Freedom/Operation Enduring Freedom,” June 12, 2008

DOD IG Report No. IE-2008-003, “Observations and Critique of the DoD Task Force on Mental Health,” April 15, 2008

Army

Army Audit Report No. A-2011-0008-IEM, “Army Warrior Care and Transition Program,” October 21, 2010

Navy

Naval Audit Service Report No. N2009-0046, “Marine Corps Transition Assistance Management Program - Preseparation Counseling Requirement,” September 15, 2009

Naval Audit Service Report No. N2009-0009, “Department of the Navy Fisher Houses,” November 4, 2008

Appendix C. Reporting Other Issues

We are performing the Assessment of DOD Wounded Warrior Matters at multiple Army and Marine Corps locations and plan to report on each location separately. This report focused on whether the programs for the care, management, and transition of Wounded, Ill and Injured Marines at the Wounded Warrior Battalion – East, Camp Lejeune, North Carolina, were managed effectively and efficiently.

We also plan to report on issues, concerns, and challenges that were common amongst most, if not all, the Wounded Warrior Battalions and detachments at the conclusion of our Marine Corps site visits. That report or multiple reports will be provided to appropriate organizations to provide information on or identify corrective actions addressing those issues, concerns, and challenges. Those organizations may include but are not limited to the Office of the Deputy Under Secretary of Defense for Wounded Warrior Care and Transition Policy; the Deputy Commandant for Manpower and Reserve Affairs; the Wounded Warrior Regiment, and the U.S. Navy Bureau of Medicine and Surgery.

This appendix captures issues, concerns, and challenges we identified at the WWBn-East and Naval Hospital Camp Lejeune (with corresponding page references noted) that may likely be included in an additional report(s). We may issue an additional report(s) before the conclusion of our Marine Corps site visits if we consider these other matters of interest urgent.

Table 6. Potential Items for Future Reports

Issue, Concerns, and Challenges	Report Reference(s)
Difference in the Delivery of Healthcare for Active Duty, Guard, and Reserve Warriors?	Page 25-26
Timely Access to Specialty Care	Page 50-56
Lengthy Transition Times	Page 57-62
Medical Case Management Staffing	Page 63-65
Medication Management	Page 66-73

Appendix D. Office of the Secretary of Defense for Health Affairs Comments



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

10 Feb 2012

HEALTH AFFAIRS

MEMORANDUM FOR DEPUTY INSPECTOR GENERAL, DEPARTMENT OF DEFENSE:

SUBJECT: Department of Defense Response to the Department of Defense Inspector General Draft Report, Project No. D2010-D000SPO-0209.002, "Assessment of DoD Wounded Warrior Matters – Camp Lejeune"

This is the Office of the Secretary of Defense for Health Affairs response to the Department of Defense Inspector General (DoD IG) Draft Report, "Assessment of DoD Wounded Warrior Matters – Camp Lejeune," Project No. D2010-D000SPO-0209.002, December 9, 2011, (Attachment 1). We concur with recommendation D.4.1 assigned to the Assistant Secretary of Defense (Health Affairs) and partially concur with recommendation D.3 assigned to the Undersecretary of Defense (Personnel and Readiness). We have provided detailed responses to both recommendations (Attachment 2). Additionally, we would appreciate your consideration in rewording footnote 21.

Thank you for the opportunity to review and comment on the draft report. The points of contact for additional information are Ms. Lois Kellett, Dr. Jack Smith, and Mr. Gunther Zimmerman.

A handwritten signature in cursive script, appearing to read "Karen S. Guice".

Karen S. Guice, M.D., M.P.P.
Principal Deputy

Attachments:
As stated

**Assessment of DoD Wounded Warrior Matters –Camp Lejeune
Project No. D2010-D00SPO-0209.00, December 9, 2011**

TMA RESPONSE TO RECOMMENATIONS

RECOMMENDATION D.3: We recommend that the Undersecretary of Defense for Personnel and Readiness, comply with the requirement to replace the existing Directive-Type Memorandum 08-033, Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the Military Health System, and develop a DoD Instruction establishing adequate Medical Case Managers staffing ratios specific to Wounded Warrior programs based on patient care acuity, complexity, and evidence-based practices.

TMA Response: Concur. TMA concurs with the recommendation to comply with transition of DTM 08-033 into a DoDI and concurs in working towards establishing case manager staffing ratios that will consider variables associated with acuity and complexity of care coordination requirements, and consistent with the statutory requirements of the National Defense Authorization Act for Fiscal Year 2008, Section 1611 (c)(3)(C) recognizing that the secretaries of the Military Departments concerned may waive such limitation with respect to a given manager for not more than 120 days in the event of unforeseen circumstances.

RECOMMENDATION D.4.1: Office of Assistant Secretary of Defense, Health Affairs, ensure that the Pharmacy Data Transaction Service/Armed Forces Health Longitudinal Technology Application interface adequately supports the medication reconciliation for prescriptions not ordered in the Composite Health Care System.

TMA Response: Concur. Efforts are underway to enhance the medical reconciliation capability within AHLTA/Composite Health Care System (CHCS). Currently, DoD healthcare providers are able to document changes to medication orders made by DoD providers but are unable to do so for medication orders from non-DoD providers, to include VA and civilian providers. Two system change requests (SCRs) have been approved to address this:

- Allow users to mark as "Taking/Not Taking" each patient's current medications regardless of the source system." For example, the source systems include but are not limited to AHLTA, CHCS, VA, or PDTS. This update can be done during a patient encounter or without initiating an encounter.
- Change the status of a medication to "Taking/Not Taking" when a user marks an over the counter (OTC) medication as "Taking/Not Taking".

Currently, these enhancements are targeted for funding in Fiscal Year (FY) 2014.

Assessment of DoD Wounded Warrior Matters –Camp Lejeune
Project No. D2010-D00SPO-0209.00, December 9, 2011

TECHNICAL COMMENT

- Page 30. Recommend the following changes be made on page 30. Rationale: With the deployment of AHLTA Block 2 halted (which included a dental application and optical ordering system), AHLTA remains the DoD outpatient electronic health record. AHLTA is only available at Military Treatment Facilities.

Current

²¹ **Armed Forces Health Longitudinal Technology Application (AHLTA) is the medical and dental information system that generates a (sic) maintains a comprehensive, lifelong, computer-based patient record for every Soldier, Sailor, Airman, and Marine; their family members; and others entitled to DoD military health care.**

Recommended

²¹ **Armed Forces Health Longitudinal Technology Application (AHLTA) is the clinical information system that generates and maintains a lifelong, computer-based outpatient record for every Soldier, Sailor, Airman, and Marine; their family members; and others entitled to DoD military care who receives care in a military treatment facility.**

Bureau of Medicine and Surgery Comments



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

5041
Ser M00IG/E11UN093001313
31 Jan 12

From: Chief, Bureau of Medicine and Surgery
To: Ambassador Kenneth P. Moorefield, Deputy Inspector
General, Department of Defense

Subj: ASSESSMENT OF DOD WOUNDED WARRIOR MATTERS-CAMP LEJEUNE

1. In response to the draft report "Assessment of DoD Wounded Warrior Matters-Camp Lejeune, the Bureau of Medicine and Surgery concurs with the comments noted in the report.
2. The comments from BUMED M9-WII Program Support is approved. BUMED will take necessary actions to correct noted observations and recommendations noted in the report.
3. My point of contact is Mr. Stephen Sheehan who may be reached at [REDACTED]

A handwritten signature in black ink, appearing to read "M. L. Nathan".

M. L. NATHAN

DoD IG Report: Assessment of DoD Wounded Warrior Matters – Camp Lejeune
Project No. D2010-D00SPO-0209.002
January 9, 2012

BUMED M94 (WII Program Support) Comments

Overall Comments:

Navy Medicine welcomes the opportunity to respond to the recommendations for improved wounded warrior care at Naval Hospital Camp Lejeune.

Recommendations:

D.1.1a Establish policies and procedures to uniquely identify Wounded Warriors assigned or attached to a Wounded Warrior Battalion in the Composite Health Care System, so that established DoD TRICARE access to care standards specifically for the Wounded Warrior population can be tracked.

Concur – with comments

COMMENTS:

In July 2011, BUMED M9 sponsored a multi-regional, multi-disciplinary working group to examine programs/systems currently used to collect/monitor deployment or wounded ill and injured data/information. The most promising platform appears to be the Combat Neurotrauma Registry (CNR), developed by staff at the Naval Center for Combat and Operational Stress Control (NCCOSC). This registry was originally developed to support the Southern California Office of Neurotrauma (ONT) efforts to identify, monitor and track service members diagnosed with traumatic brain injury (TBI). CNR is deployed at Naval Medical Center San Diego, Naval Hospital Camp Pendleton and Naval Hospital Twenty-Nine Palms. With significant modifications and linkage to NMCPHC databases, this CNR platform will likely provide the architecture for a usable WII registry for the regions, and the ultimate linkage to the Composite Health Care System.

Additionally, one of our clinical regions is incorporating assigning wounded warriors with Health Care Delivery Code 0415 with DEERS/CHCS. Enterprise-wide solution is pending further review of all options.

D.1.1b Establish policies and procedures to ensure Wounded Warriors assigned or attached to a Wounded Warrior Battalion receive every medical appointment within established DoD TRICARE access to care standards.

Concur – with comments

COMMENTS:

Wounded warriors assigned to the Wounded Warrior Battalion typically are afforded the services of clinical case management at the military treatment facility and or embedded within the Battalion. These warriors are also enrolled/assigned a primary care provider for managing all health concerns within the Medical Home Port. Central to the mission of this healthcare team, is to ensure said warriors are afforded timely access to quality care with the military treatment facility and purchase care. Resolution of any clinical staffing concerns addressed below should assist in alleviating any access to care challenges. Guidance on the existing policies and procedures will continue to be discussed to ensure current and emerging gaps and challenges are addressed.

D.1.1c Based on results of the Naval Hospital Camp Lejeune manpower study and the Commander's recommendations (see below), take appropriate actions to provide adequate staffing for all specialty medical care activities assigned to Camp Lejeune.

Concur

COMMENTS

Navy Medicine will assess the validated results of the referenced manpower study for any follow on staffing actions.

BUMED M3B22 (BUMED Navy Pharmacy Consultant / Specialty Leader) Comments

Overall Comments:

In response to the DoD IG report, it should be noted that there is overlap in the recommendations under Section C.3 and Section D.4.; therefore, the responses can apply to multiple recommendations.

Recommendations:

D.4.1. Office of Assistant Secretary of Defense, Health Affairs, ensure that the Pharmacy Data Transaction Service/Armed Forces Health Longitudinal Technology Application interface adequately supports the medication reconciliation for prescriptions not ordered in the Composite Health Care System.

[Note comments also apply to D.3.1.b]

Concur with comments

All prescriptions for Wounded Warriors (or any TRICARE beneficiary) filled at the Military Treatment Facility (MTF) populate the Military Health System's pharmacy profile screening application called Pharmacy Data Transaction Service (PDTS). All prescriptions prescribed by civilian providers in the community and filled in non-MTF pharmacy settings by Wounded Warriors (or any TRICARE beneficiary) populate PDTS. Prescriptions are reconciled appropriately via PDTS when entered by a provider using AHLTA/CHCS and again when presented to a Retail Network Pharmacy, the TRICARE Mail Order Pharmacy or a MTF pharmacy. Prescriptions not entered through AHLTA/CHCS (i.e. civilian provider) would be reconciled when presented to a Retail Network Pharmacy, the TRICARE Mail Order Pharmacy or a MTF pharmacy. Only if a Wounded Warrior (or any TRICARE beneficiary) chooses not to use TRICARE for their prescription (i.e. pays with cash), will PDTS not be reconciled and populated.

The statements attributed to battalion leaders on page 45 of the DoD IG report that, "there was no real check between civilian and military medical providers of medications. As a result, Marines could and did duplicate prescriptions in excessively large quantities because the two systems were not reconciled", are inaccurate. The report should clarify the purpose and functionality of PDTS. Since TRICARE beneficiaries have the ability to choose multiple Points of Service (Retail, Mail-order, and MTF), PDTS is populated with all prescriptions and the systems are reconciled to provide pharmacists with the ability to conduct drug interaction checks along with other checkpoints concerning the prescription.

In addition, military providers using AHLTA or CHCS have the ability to review the patient's prescriptions profile, regardless of which Point of Service the patient selected under the TRICARE Pharmacy benefit. Providers receive hard edits in AHLTA (data supplied from PDTS) for therapeutic duplications, drug interactions and overlapping prescriptions that they review and can only proceed with an override.

D.4.2.a Update command policies and procedures for overall medication management to include polypharmacy management, medication reconciliations, and pain management practices including use of alternative therapies.

Concur with comments

A review of directives and procedures for medication management may mitigate some of the issues identified in the report, but licensed professionals are generally given latitude on selection

of treatment options and how pharmaceuticals are prescribed, dispensed, and administered, based on professional judgment and specific patient presentation.

D.4.2.b Coordinate with Wounded Warrior Regiment to determine if the Electronic Medication Management System is an appropriate method to assist in the proper dispensing of medications to Warriors assigned or attached to Wounded Warrior Battalions.

[Note comments also apply to C.3.1.a]

Non-concur

The EMMA system is a vendor-specific system. The DoD IG report cites EMMA on pages 45 and 66. There are other electronic supported and non-electronic means to meet the identified requirement at the wounded warrior barracks, so the DoD IG report should not recommend a vendor-specific system. Evaluation of the most appropriate method to control medication access/administration can be accomplished, to include patient population studies.

D.4.3

We recommend that the Commanding Officer, Navy Medicine East, develop and implement policy and procedures to ensure that there is a regularly scheduled and/or available procedure for discarding of Warriors unused and/or un-needed medications.

[Note comments also apply to C.3.1.c – Establish procedures for the disposal of prescription medications that are no longer needed by the Wounded Warrior.]

Concur with comments

Since a large percentage of prescriptions for Wounded Warriors are controlled substances, there is no lawful method for hospital or battalion staff to receive or “take-back” these controlled medications from the patient. The Controlled Substances Act prohibits this so there are limited options concerning returns of unneeded medications, except to law enforcement personnel. Allowing the patients to drop-off medications in a secure locked box is an option, but per regulations and consultations with the DEA, the box must be monitored and guarded 24 hours a day. This severely limits accessibility for patients.

It should be noted that previous take-back initiatives run by DEA and local command have had extremely low participation rates. An alternate solution is to limit the total amount of medication dispensed by increasing the frequency and decreasing the size of refills (e.g. dispense a 2 day supply) vs. developing a means to retrieve excess quantities from the Wounded Warriors.

There is pending regulatory changes as a result of the Safe and Secure Drug Disposal Act that was signed into law on October 12, 2010, but until the proposed rulemaking is issued by the Attorney General, there is no process to follow. This law is intended to allow individuals to

more easily and safely dispose of controlled substances while reducing the chance of diversion. Under the law, a patient who has "lawfully obtained a controlled substance" may now deliver unused portions of that controlled substance to another entity for destruction without a Drug Enforcement Agency registration if: 1) the person receiving controlled substance is "authorized" to do so under the law; and 2) the drug is disposed of in accordance with regulations issued by the Attorney General.

The law addresses a longstanding issue where patients were not allowed to return drugs to a DEA registrant because such a return would be outside the "closed chain of distribution" established by the Controlled Substances Act. This law will provide DEA with the authority to promulgate regulations to facilitate such returns but does not authorize DEA to mandate that entities establish a disposal program.

Wounded Warrior Regiment and Wounded Warrior Battalion East Comments



UNITED STATES MARINE CORPS
HEADQUARTERS UNITED STATES MARINE CORPS
WOUNDED WARRIOR REGIMENT
1998 HILL AVENUE
MCB QUANTICO, VA 22134-5001

IN REPLY REFER TO:

1000

CO

JAN 10 2012

FIRST ENDOSEMENT on CO, Wounded Warrior Battalion East ltr 1000
CO Of 22 Dec 11

From: Commanding Officer
To: Office of the Inspector General, Department of Defense
Subj: ASSESSMENT OF DOD WOUNDED WARRIOR MATTERS - CAMP LEJEUNE
(PROJECT NO. D2010-D00SPO-0209.002)
Ref: (a) DODIG Memorandum of 9 December 2011 (NOTAL)

1. I concur with the comments provided by the CO, Wounded
Warrior Battalion East.

2. Per the reference, I concur with recommendations D.2.1.a,
D.2.1.b, D.2.1.c, D.2.1.d, and D.2.1.e, with the following
comments:

a. WWR currently generates a weekly brief for DC, M&RA's
action that captures the status of Marines in the Medical
Evaluation Board (MEB) and (Physical Evaluation Board) PEB
phases. By-name rosters of Marine cases exceeding phase
processing goals are provided biweekly to the Bureau of Medicine
and Surgery (BUMED) and PEB.

b. It should also be noted that since the time of the DoD
Inspector General's review, there have been ongoing efforts to
improve IDES performance. In addition to hosting regular BUMED
teleconferences with IDES stakeholders, DC, M&RA has been
providing Marine Corps leadership with detailed IDES
information, which has resulted in their ability to work closer
with the Regional Medical Commanders on specific issues
impacting IDES performance. Naval Hospital Camp Lejeune has
proved to be the most successful in making IDES work as
intended.

3. The command point of contact is Mr. Marvin Mowen, Command
Inspector, [REDACTED]


JOHN L. MAYER

Copy to:
CMC (MF)



UNITED STATES MARINE CORPS
WOUNDED WARRIOR BATTALION-EAST
PSC BOX 20008
CAMP LEJEUNE, NC 28542-0008

IN REPLY REFER TO
1000
CO
22 Dec 11

From: Commanding Officer, Wounded Warrior Battalion-East
To: Office of the Inspector General, Department of Defense
Via: Commanding Officer, Wounded Warrior Regiment

Subj: ASSESSMENT OF DOD WOUNDED WARRIOR MATTERS - CAMP LEJEUNE (PROJECT
NO. D2010-D00SPO-0209.002)

Ref: (a) DODIG Memorandum of 9 December 2011 (NOTAL)

1. Pursuant to the reference, this letter comments on the recommendations provided in the draft report by the Inspector General, Department of Defense as the result of their visit to Wounded Warrior Battalion-East in September 2010.

2. **Introduction to response:** The DoD IG team was granted unlimited access to staff members, patients, and families of wounded warriors during their visit in September 2010. Although their visit was over 15 months ago, and we were unfamiliar with their findings until receipt of the draft report, it should be noted that the following changes took place between September 2010 and December 2011 that have a direct impact on the findings relevant to the report:

a. In July 2011, the wounded warrior barracks moved into a new 3-story, 100-room/200-man barracks located at hospital point, Camp Lejeune. The new wounded warrior complex is ¼ mile from the Naval Hospital, thus granting more direct access to medical care and administrative assistance during the Integrated Disability Evaluation System. Per DoD memo 18 September 2007 (DoD Housing Inspection Standards for Medical Hold and Holdover Personnel), each room includes the following amenities at no cost to the occupants of the barracks:

- 32" flat-screen TV
- Cable television
- DVD player
- Internet service (hard-wire), plus WiFi in the common areas
- Local telephone service

b. An organizational climate survey was completed in February 2011, by wounded warriors assigned to WWBn-E at Camp Lejeune. Appropriate reinforcing behaviors and corrective actions were implemented as a result of the climate survey. Additionally, I have directed another Defense Equal Opportunity Climate Survey to be completed in February 2012. This survey will also target the issues raised by wounded warriors during the DoD IG visit to ensure those problem areas do not still exist.

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c. The Battalion leadership implemented quarterly New Join Orientation briefs for all wounded warriors, their family members, and all new battalion/company staff members. The first presentation was conducted in September 2011, the second in December 2011. Topics presented include Recovery Care Coordinators, IDES Process, Medical Case Management, Career Planning (PLD/EPLD), Warrior Athlete Reconditioning Program, Transition Assistance, Charitable Organizations, etc. These events are targeted to educate wounded warriors, family members, and staff members on the resources available to them.

d. This Command conducts unannounced SACO-facilitated urine drug screening in compliance with MCO 5300.17 in order to detect unauthorized consumption of controlled or illegal substances. The Command has also involved NCIS and military working dogs to find unauthorized drugs. These actions serve as deterrent measures necessary to support prevention programs and enhance personal and mission readiness. Additionally, medical urinalysis screening is a key tool used by the WWBn-E medical staff to provide a more complete picture of patients' pain medication use. This is an important tool in the treatment of chronic pain. Medical urinalysis screening can provide accurate, periodic monitoring of patients' pain medication use. The goal is to reduce the risk of a patient's misuse or abuse of a prescribed medication. It also enables medical staff to learn about any controlled substances a patient is taking and potentially harmful drug-to-drug interactions. The medical urinalysis screening ultimately enables the physician to better understand pain treatment effectiveness, and helps create better patient outcomes while enhancing safety. Medical urinalysis screening is conducted regularly in accordance with Battalion Order 6000.1B, "Procedures for Facilitation of the Wounded Warrior Battalion-East Prescription Reconciliation Program," and is not shared with battalion leadership in order to safeguard patient privacy.

e. Regarding child care availability aboard Camp Lejeune, the Child Youth and Teen Programs recently opened one new Child Development Center (CDC), with two more CDCs scheduled to open in January 2012. By the end of 2012, child care spaces will have increased from 600 to 1,800 (+1,200) allocations for children aged 6 weeks to 5 years. While not routinely available, priority child care for wounded warriors attending medical appointments is available if facilitated through the battalion Family Readiness Officer (FRO), as necessary. The FRO has assisted multiple families with priority child care over the past year, and routinely announces her availability to do so at various meetings, via quarterly newsletters, and via family readiness e-mail notifications. Discounted rates are available to those in need on a case-by-case basis.

3. Recommendation C.1. We recommend that the Commander, Wounded Warrior Battalion-East develop procedures and training for Warriors to ensure that they are active participants in the development of their Comprehensive Transition Plan, and that it is individually tailored and effective in fulfilling their transition goals.

Wounded Warrior Battalion-East comment: Concur with comment. Since the DoD IG's visit in the fall of 2010, process changes were put into place to improve usage and awareness of the Comprehensive Transition Plan (CTP);

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now referred to as the Comprehension Recovery Plan (CRP).

- The DoD's Wounded Warrior Care and Transition Policy (WWCTP) released the Recovery Coordination Program Support Solution (RCP-SS) to the USMC in October, 2010 and the Marine Corps met full implementation in April 2011.
 - RCP-SS is the technology tool that houses the CRP.
 - RCP-SS allows RCCs to create, store, and update the elements of the CRP including needs, goals, actions, and completion dates.
 - RCP-SS provides a standard CRP across the Wounded Warrior Regiment and allows a CRP to be easily transferred from one RCC to another. The standard format and easy transfer enables the RCC program to provide continuity and stability to Marines when they transfer from one MTF or location to another.
 - RCP-SS allows program management and Wounded Warrior Regiment leadership to view any CRP at any time. This enables care coordination and a mature quality assurance program.
 - As of December 2011, the USMC RCC Program was the first service program to have fully implemented RCP-SS.
- Since April 2011, the RCC Program has implemented a robust training program to provide RCCs with the tools they need to properly document a Marine's needs, goals, and required actions in the CRP.
 - RCCs are trained on methods to capture Marine's needs, translate those needs into concrete goals and then provide specific, actionable steps that the Marine can take to meet those goals.
 - The CRP is written in the Marine's own words encouraging buy-in and follow-through. The RCC works with the Marine to set meaningful goals, determine achievable steps, and decide the best timeline for completion of actions. The RCC maintains the status of each step so the CRP remains a living document.
- RCCs, Section Leaders, and Wounded Warrior Battalion transition staff work closely to ensure that Marine's goals are realized and that efforts are coordinated.
- Since August 2011, the RCC Program has implemented a quality assurance program to ensure consistent CRP development and documentation. RCC Program Management audits 10% of RCC caseloads every quarter and conducts spot audits daily.

4. Recommendation C.2. We recommend that the Commander, Wounded Warrior Battalion-East develop a comprehensive training and orientation program, to include roles and responsibilities of recovery team members, and ongoing educational training opportunities to ensure that recovery team

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members are prepared to deal with the challenges of helping Wounded Warriors heal, recover and transition either back to active duty or return to civilian life.

Wounded Warrior Battalion-East comment: Concur with comment. Over the past 18 months, we have created and implemented a robust training program for all military and civilian staff.

First, we conducted a series of resilience and ongoing education sessions for WWBn-E staff. Classes are facilitated by professional instructors and are mandatory training for all battalion staff, both military and civilian; including contractors and direct support personnel (i.e., medical case managers, medical board clerks, licensed clinical consultant, etc.). Resilience training and ongoing education classes include:

- Classes conducted multiple times to provide staff with an understanding of PTSD and TBI from a caregiver's perspective, and conveyed knowledge that can be applied to develop skills that promote effective management and supportive interactions with service members that have overlap of psychiatric, cognitive, and/or neurological impairment.
- Stress management classes conducted to address caregiver burnout. Training enabled participants to identify elevated stress levels, which can adversely affect the work environment, and implement coping mechanisms. Information provided during the training expanded the staff's knowledge base, wellness, increased staff morale, camaraderie, and teamwork.
- Other mandatory classes over the past 15 months for staff included: Ethics and Charitable Organizations; Acceptance of Gifts; Substance Abuse Rehabilitation; Spirituality; Medication Safety; Internal Communication, Teamwork, Leadership, Client Relations, Presentation Skills, Conflict Resolution, Appropriate Humor in the Work Place, and Effective Team Building.
- Elective courses were offered to battalion and company staffs by the WWBn-E Licensed Clinical Consultant over the past 12 months: Compassion Fatigue, Understanding Culture, Grief, Substance Abuse, Survivor's Guilt, Stress Management, Behavioral Health Emergencies, Post Traumatic Stress, and Traumatic Brain Injury.

All Wounded Warrior Regiment recently implemented computer-based training courses that are required to be completed by all staff members, military and civilian. Courses include: Integrated Disability Evaluation System; Identifying Signs and Symptoms of Suicide; Intervening in Suicidal Crisis; Fundamentals of Reserve Medical Entitlements Determination; fundamentals of Traumatic Servicemembers' Group Life Insurance; Introduction to the District Injured Support Coordinators; Veterans Support Organizations; Recovery Team Meetings; Care for the Caregiver; The U.S. Marine Corps Permanent Limited Duty/Expanded Permanent Limited Duty Programs; Special

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Compensation for Assistance With Activities of Daily Living, etc.

Special staff members attended the following courses based on requirements of their respective positions:

- North Carolina Area Health Education Center Workshop, "Leading Oneself and Others through Change and Transition" (October 2011). The purpose of this course was for participants to gain insight and skills to enhance individual resiliency in the face of uncertainty and rapid change.
- Discussing Therapeutic Options for Multiple Sclerosis; Returning from War with Invisible Wounds; Brain Train Mastering the Captain's Log; 2011 Smithsonian/Navy Medicine Conference Series Wounded Warrior Care; Annual Case Management Society of America Conference; 5th Annual Defense and Veterans Brain Injury Summit, 4th Annual Military Health Symposium, "Striving Towards Enhanced Warfighter Mental and Physical Healing and Strength" (scheduled for March 2012).

5. Recommendation C.3.1.a. Determine the appropriateness of and implement the Electronic Medication Management System for designated "high-risk" and other potentially vulnerable Warriors.

Wounded Warrior Battalion-East response: Concur with comment.

Wounded Warrior Battalion-East commanding officer and selective staff members were briefed on the Electronic Medication Management Assistant (EMMA) system early 2010 and convinced of its application for "high-risk" and vulnerable wounded warriors. However, as stated in the draft DOD IG Report, the EMMA system has not been approved by the Navy Bureau of Medicine and Surgery (BUMED); therefore, it has not yet been implemented.

6. Recommendation C.3.1.b. Improve medication reconciliation procedures to ensure medications prescribed by civilian providers in the community are reconciled with those prescribed at the Naval Hospital to ensure the quantities of medications available to wounded Warriors are appropriate and not contraindicated.

Wounded Warrior Battalion-East response: Concur with comment.

At the time of the DoD IG Team's visit in September 2010, the battalion staff was in the process of reviewing the battalion's Prescription Risk Management Program. Since then, we promulgated Battalion Order 6000.1B, "Procedures for Facilitation of the Wounded Warrior Battalion-East Prescription Reconciliation Program," which was signed in October 2011.

Per our lines of operation, which encompass the mind, body, spirit, and family of each of our wounded warriors, this new policy provides a tool with which WWBn-E staff can supervise the proper medication accountability and dosage of each Marine and Sailor. The directive focuses on three main areas:

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- Medication inventory,
- Pain management, and
- Identification of and assistance to high risk patients.

The intent of this program is to create a structured, individualized medication accountability process that provides an effective tool for monitoring medication use. The end state is a patient population that is taking medication as prescribed and is educated on maintaining their own personal medication accountability. This document explains the processes and procedures by which the leaders of WWBn-E will support and educate the Marines and Sailors under their charge.

To ensure our Marines aren't "doctor shopping," all WWBn-E patients with chronic pain issues have their pain managed by either the pain clinic at the Naval Hospital or by the WWBn-E physician. The pain clinic helps titrate medications for unstable patients. Once stable the WWBn-E physician becomes their exclusive narcotic prescriber. As stated in Battalion Order 6000.1B: "No WWBn-E patients who are prescribed narcotics or sedatives will be permitted to go to a pain management provider or clinic in the civilian community unless authorized by the unit or detachment PCM." If narcotics are procured outside the network, they are in violation of battalion directive and subject to administrative or disciplinary action.

7. Recommendation C.3.1.c. Establish procedures for the disposal of prescription medications that are no longer needed by the Wounded Warrior

Wounded Warrior Battalion-East response: Concur with comment.

In May 2011, we were advised that under current Federal law, only patients (recipients of these medications) can dispose of their medications. Under no circumstances should a provider, the pharmacy, or other hospital personnel accept the return of medications or drugs from a patient. The only legal and proper way to do this currently is to have the patient give their medications to a Federal law enforcement officer. On Camp Lejeune, those working under the Provost Marshal are considered Federal law enforcement officers. Therefore, at the time of the IG Team's visit, the only authorized prescription medical disposal program that existed aboard Camp Lejeune was a quarterly base wide medical turn-in coordinated at the Post Exchange (PX) by the Base Provost Marshal in coordination with local and federal law enforcement. Since that time, the battalion coordinated a separate turn-in of prescription medicine at the WWBn-E Barracks. The event was conducted by the Base Provost Marshal in November 2011 with minimal results.

8. The following additional comments/recommendations are provided:

Subject: Wounded Warrior Battalion East Sites (p. 4).

The sites identified were correct at the time of the visit, but the following reflect permanent changes as of December 2011:

- Delete: National Naval Medical Center, MD AND Walter Reed Army Medical Center, DC; Add: Walter Reed National Military Medical Center, Bethesda, MD

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(PROJECT NO. D2010-D00SPO-0209.002)

- Delete: Brooke Army Medical Center, TX; Add: San Antonio Military Medical Center, San Antonio, TX

Subject: 9-Block Representatives (p. 16). The information in the report is incorrect. Some of the individuals identified do not (and have never) attended, and some who do (and have since prior to visit) attend 9-Block are not listed. Some billet titles are incorrect:

- Delete: Command Sergeant Major
- Add: Battalion Sergeant Major
- Delete: Operations Officers
- Add: Battalion Commanding Officer and/or Battalion Executive Officer
- Delete: Family Readiness Officer
- Add: Family Support Coordinator
- Delete: Medical Case Manager Advisor
- Add: Medical Case Management Advisor
- Delete: Platoon Leaders
- Add: Medical Board Clerk

Appendix A (Page 87)

Replace "Family Readiness Coordinator" with "Family Support Coordinator"
Replace "Medical Case Manager Advisor" with "Medical Case Management Advisor"

9. As evident in this letter, process improvements in wounded warrior care and family support are ongoing. We continue to enhance the initiatives noted by the DoD IG team as "noteworthy practices," as well as identify challenges that inhibit support. Immediate corrective actions are taken to increase program effectiveness in providing quality and timely care and services to wounded warriors and their families.

10. Point of contact at this command is Mr. Craig E. Stephens, GS-14 who can be reached [REDACTED]

/s/ N. E. Davis (22 Dec 11)
LtCol USMC

Naval Hospital Camp Lejeune Comments



DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
100 DREWSTER BLVD
CAMP LEJEUNE, NORTH CAROLINA 28547-2534

IN REPLY REFER TO
5041
00
8 Feb 12

From: Commanding Officer, Naval Hospital, Camp Lejeune
To: Commander, Navy Medicine East

Subj: ASSESSMENT OF DOD WOUNDED WARRIOR MATTERS

Ref: (a) eKM Action E1UN93001313-MOIG Tasked of 12 Jan 12
(b) CO, NAVHOSPCAMLEJ ltr 5041 00 of 17 Jan 12

Encl: (1) CDR NME ltr 5320 Ser 09/120059 of 30 Jan 12
(2) NAVHOSPCAMLEJNINST 6320.55C

1. Per reference (a) detailed narrative recommendations are provided as requested and additional information is provided to reference (b):

a. Recommendation D.1.2: Navy Medicine East (NME) has initiated a Manpower study regarding Wounded Warrior Specialty care and plans to have it completed no later than April 2012. A letter from NME is attached as enclosure (1).

b. Recommendation D.4.4.a: Regarding the Naval Hospital Camp Lejeune Instruction 6710.5A: The pharmacy is leading a multidisciplinary team involving all aspects of our healthcare team to evaluate the revisions that are needed to the current Naval Hospital Instruction providing guidelines for Controlled Medication Utilization. The intent is to ensure Command guidance is given to providers and supporting staff in regards to narcotic and controlled medication prescribing and usage, preventing potential diversion or overuse, and providing strict guidelines for poly-pharmacy patients.

Since a large majority of controlled medication prescribing is related to pain patients, a focus will be on this population which includes the Wounded Warriors. Items open to revision will include: patients seeing more than one provider for pain, pain contracts not enforced, consequences of pain contract violations, obligations of patient care for the Emergency department provider, and overall internal communication for providers treating pain patients. Establishing commonalities of controlled medication prescribing for Naval Hospital Camp Lejeune could eliminate or minimize potentially unwanted outcomes to include addiction or illegal selling of controlled medications.

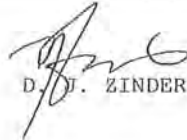
Subj: ASSESSMENT OF DOD WOUNDED WARRIOR MATTERS

The instruction will provide Naval Hospital Camp Lejeune guidance for the safe and effective prescribing of controlled medications. The established policies will be monitored and evaluated as dictated periodically utilizing easily retrievable CHCS reports measuring the program effectiveness.

The final proposed instruction is due to Naval Hospital Camp Lejeune leadership by 1 April 2012.

c. Recommendation D.4.4.b: Naval Hospital Camp Lejeune Instruction 6320.55C is provided as enclosure (2).

2. Should any further information be needed, CAPT Swap, Executive Officer, is my point of contact for this matter and can be reached at [REDACTED]


D.J. ZINDER



DEPARTMENT OF THE NAVY

NAVY MEDICINE EAST
620 JOHN PAUL JONES CIRCLE
PORTSMOUTH, VIRGINIA 23708-2106

5320
Ser 09/120059
30 Jan 12

From: Commander, Navy Medicine East
To: Commanding Officer, Naval Hospital Camp Lejeune
Subj: WARRIORS' TIMELY ACCESS TO SPECIALTY MEDICAL CARE
Ref: (a) DoD Office of IG Draft Report on Assessment of DoD
Wounded Warrior Matters- Camp Lejeune Project NO.
D2010-D00SPO-0209.002
(b) Phonecon between Acting COS and CO, NHCL, 30 Jan 12

1. Per references (a) and (b), a manpower study to review Warrior's Timely Access to Specialty Medical Care is being conducted by the Navy Medicine East Manpower Team. This study is anticipated being completed by 30 April 2012.
2. My point of contact is LCDR Kathryn J. Krause, who may be reached [REDACTED]

L. T. DOWNS
Chief of Staff
Acting

Enclosure (1)



Inspector General Department of Defense

